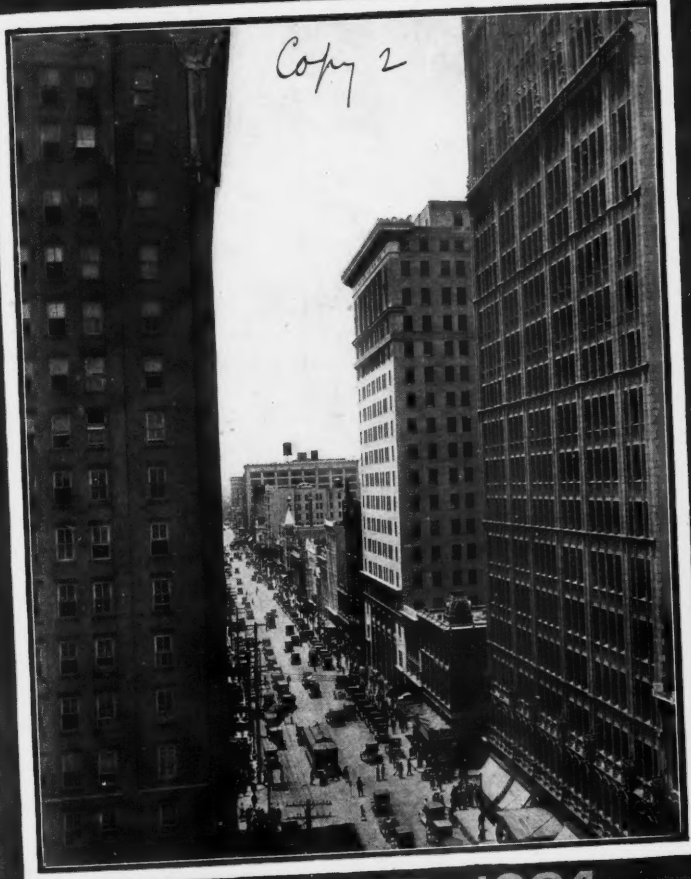
THE DENTAL DIGEST



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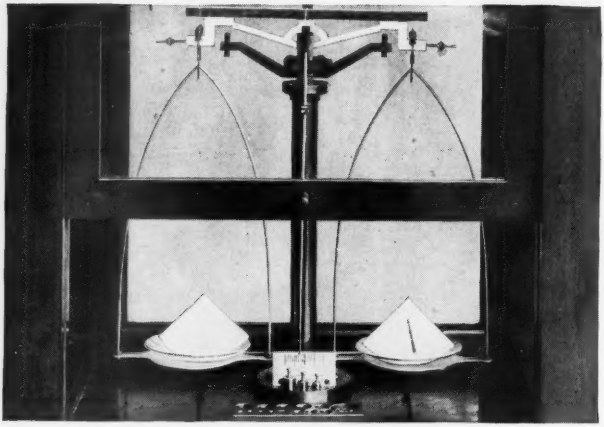

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THE
DENTAL DIGEST

Vol. XXX OCTOBER, 1924 No. 10

Survey of the Narcotic Problem*

By Carleton Simon, M.D.

Special Deputy Police Commissioner in charge of Narcotic Division of the New York City Police Department, before the Medical Society of the County of New York, January 28, 1924, at New York Academy of Medicine.

Of late years there has been considerable controversy as to whether narcotic-drug addiction should be viewed as a medical question or as a police problem. We may go on forever debating the question academically, but why not have the facts?

This latter is exactly what I have undertaken to get. Instead of relying on estimates based upon hearsay and exaggeration I have gathered exact statistics.

In June, 1923, questionnaires were sent to all the physicians and dentists in the State of New York.

The one to the physicians asked:

Amount of morphine prescribed in 1922.
Amount of heroin prescribed in 1922.
Amount of cocaine prescribed in 1922.
Number of narcotic addicts treated in 1922.
Do you believe heroin necessary in your practice?
Do you believe cocaine can be advantageously replaced by non-habit-forming synthetic drugs, such as novocain or similar preparations?

The one to the dentists contained the following inquiries:

Amount of cocaine used in 1922.
Do you believe cocaine can be advantageously replaced by non-habit-forming synthetic drugs, such as novocain or similar preparations?

The animating purpose in making these inquiries of physicians and dentists as to the practical experience acquired in their professional use of habit-forming drugs was:

1. To determine whether narcotic-drug addiction is a medical issue or a police problem, or both.
2. To gain statistical knowledge as to the number of medical

* At the request of Hon. Royal S. Copeland, Senator from New York, this *Survey* was ordered on May 16, 1924, to be published in the *Congressional Record*.

drug addicts treated in this State during a given period of time, from which reasonable approximations or conclusions may be drawn.

3. To ascertain the quantity of narcotics prescribed by the physicians and dentists in the State of New York.

No attempt was made to ascertain the amount of narcotics consumed by the public and furnished to the market legitimately through druggists in the form of paregoric, proprietary medicines, etc., nor were hospitals taken into consideration. It was my opinion that addicts treated in hospitals had previously been under treatment in the private practice of physicians. Therefore, in order to avoid duplication, no hospital statistics were gathered.

4. To obtain general information as to the desirability and possibility of the practitioner substituting non-habit-forming drugs, without lessened efficacy of his service to his patients.

5. To secure information as to the necessity of heroin in the practice of medicine.

There was no intention to suggest any restrictions to the constitutional right of the physician to prescribe whatever he deemed necessary to his practice. In the light of the investigations here reported and which may hereafter be made, the profession itself should determine whether the physicians themselves should not unite in declaring heroin an outlawed drug.

6. To ascertain the quantity of cocaine used by dentists and physicians; to determine the percentage of practitioners who, in part or wholly, employ synthetic preparations having no habit-forming qualities, and to learn from those competent to judge, the efficacy of these substitutes.

It was my intention to find out what narcotics are necessary and the extent of their use and in general to show, through the census, the general trend.

Far from attempting to minimize the work of the practitioner, my aim has been to gather information so that the various viewpoints of the physicians and dentists may be available for mitigating and eradicating evils in connection with the use of habit-forming drugs.

The responses to this appeal from the medical and dental professions have been most hearty, and again furnish exhaustive evidence that the professional man is an altruist in lending his aid in the solution of great public issues. It is to be hoped that the data secured will be helpful in solving some of the vexatious problems that obtrude. A review of the returns received from the questionnaire shows as follows:

Is Drug Addiction a Medical Issue or a Police Problem?

Some medical men have been of the opinion that all that pertains

to this subject should be under the jurisdiction of the medical profession; that drug addiction is a sickness or a disease, and the addict should be regarded and treated as a sick man.

On the other hand, most of those administering the criminal laws, supported by the great majority of social workers, contend that because such a large percentage of criminals have acquired the narcotic habit the issue has become one that is inseparably connected with the regulation of crime.

The returns show that there is a medical narcotic addict who requires narcotics because of physical ailments. This type is obviously one to be handled by physicians, and every barrier should be removed so as not to embarrass the physician in according relief to such sufferers.

The far greater number, however, are the criminal drug addicts, whose addiction in its inception and in its continuance is due to vice, vicious environment, and criminal associations. The consideration of this class, the figures prove, constitutes a distinct police problem. The so-called medical addict, who will not consult the physician but purchases his narcotics from street vendors, and thus supports the illicit traffic in drugs, obviously places himself in the same class with the criminal addict. In about 10,000 arrests and hospital commitments for cure by the narcotic division of the police department during the past three years 98 per cent and a fraction frankly admitted that their addiction was due to bad associations; that there was never any medical reason for their using narcotics. The remaining 2 per cent gave various excuses for first using narcotics, principally some surgical operation or illness. At the time of their arrest there was in this minute percentage almost invariably no reason for their continuing to use narcotics; surely there was no excuse for the use of heroin and cocaine. They buy these on the street, knowing that no reputable doctor will prescribe for them. The medical addict usually confines himself to morphine, but the menu of the criminal addict is heroin and cocaine. Approximately 95 per cent of those arrested by the police in New York City are heroin and cocaine users. In other parts of the country morphine is the chief narcotic.

Heroin addiction is, however, rapidly replacing morphine addiction throughout the United States, this spread being more noticeable in the seaport cities and from them.

To those addicted to the use of an opium derivative, morphine or heroin is considered a daily necessity. Cocaine does not entail suffering if withdrawn. Heroin is preferred because of its greater potency, and because of its smaller bulk per weight it is more easily smuggled.

Number of Addicts Under Treatment

It has been asserted that the arrests of the police department represent but 10 per cent of the narcotic addicts in this State; that the greater number of addicts are being treated by the physicians as private patients. I have always taken the opposite position and controverted the criticism directed at the medical profession.

This census of the physicians of this State shows that the percentage of medical addicts is almost negligible.

Those who dispute the police point of view, that narcotic-drug addiction is an underworld problem, maintain that there is a very large number of addicts with whom the police never come in contact. They contend that the larger number and better class of addicts are treated by physicians. The replies to this questionnaire definitely settle this point.

Table 1.—Treatment of Addicts

Number of physicians questioned	14,715
Number of replies received	7,559
Percentage of replies.....per cent	51.37
Number of addicts treated during 1922 (as reported by 7,559 physicians)	775

Further analysis of the answers received to the questionnaire shows as in Table 2:

Table 2.—Treatment of Addicts

Two hundred and fifty-six physicians treated 1 addict	256
Sixty-nine physicians treated 2 addicts	138
Thirty physicians treated 3 addicts	90
Fourteen physicians treated 4 addicts	56
Four physicians treated 5 addicts	20
Three physicians treated 6 addicts	18
Two physicians treated 7 addicts	14
Two physicians treated 8 addicts	16
Three physicians treated 10 addicts	30
Two physicians treated 12 addicts	24
One physician treated 16 addicts	16
One physician treated 22 addicts	22
One physician treated 25 addicts	25
One physician treated 50 addicts	50
A total of 389 physicians treated a grand total of addicts	775

NINETY-FOUR AND EIGHT-TENTHS PER CENT, OR 7,170 PHYSICIANS, DID NOT TREAT ANY ADDICTS.

It was my desire to make an accurate survey of the medical situation, as I felt that the physician had been stigmatized by the popular idea that he was the cause of the growth of narcotic-drug addiction in this country.

Some of the addicts included in the above total of 775 treated by physicians were not what might strictly be called "medical" addicts; that is, their addiction was traceable in its acquirement to some ailment, or they were suffering from some diseased condition that required narcotics. Furthermore, most of the cases reported were of patients under treatment for cancer or other painful disease or of very old people. No question was asked as to the ages of addicts, but some physicians furnished additional information, as the following examples show:

> One physician treated 7 addicts, all old people.
>
> One physician treated 8 addicts, all over 60 years.
>
> One physician treated 8 addicts, ages of 63 to 76.
>
> One physician treated 11 addicts, all over 50, most past 70, one 87.
>
> One physician treated 16 addicts, all suffering from some chronic disease, one under 40, three under 30, others between 50 and 75.

The haunting specter of narcotism has been exaggerated to propaganda, no doubt well meaning but nevertheless misleading. It is my desire to clear away the mist that enshrouds this subject and not to overestimate nor belittle its import.

When we look for figures as to the number of narcotic users in the country or in any section or spot therein we are given the choice of a wide variety of guesses from many official sources. For New York City these estimates run as high as 250,000.

The United States Public Health Service in a bulletin issued in 1915 gave 140,000 as its highest estimate of the number of drug addicts in this country. Four years later, 1919, the congressional committee appointed to investigate this problem stated that the number of drug addicts in the United States exceeded 1,990,000, or 2 per cent of the population, 4 per cent of the adults. These are Government figures. In addition the committee viewed the situation with alarm and reported that drug addiction was increasing; that there was a nation-wide use of narcotics, and that it was being used by all classes.

I believe that these figures are inexact, but am convinced that the prevalence of narcotic-drug addiction in the underworld is nevertheless appalling.

To show even more definitely the criminality associated with drug addiction and the extent to which it has grown in the ranks of the

criminal I have selected from the arrest statistics of the narcotic division of the police department of the city of New York for 1923 a group of 741 individuals whose records showed more than five previous convictions, which are summarized in Table 3:

TABLE 3.—CRIMINALITY AND NARCOTIC ADDICTION

	Previous arrests for various crimes	Total
1 individual's record showed.....	25	25
1 individual's record showed.....	24	24
1 individual's record showed.....	23	23
1 individual's record showed.....	19	19
1 individual's record showed.....	18	18
1 individual's record showed.....	17	17
3 individuals' record showed.....	16	48
4 individuals' record showed.....	15	60
5 individuals' record showed.....	14	70
4 individuals' record showed.....	13	52
8 individuals' record showed.....	12	96
12 individuals' record showed.....	11	132
44 individuals' record showed.....	10	440
48 individuals' record showed.....	9	432
73 individuals' record showed.....	8	584
105 individuals' record showed.....	7	735
136 individuals' record showed.....	6	816
293 individuals' record showed.....	5	1,465
741 individuals, previously arrested (times)		5,056

On carefully checking up our statistics of arrests and commitments to hospitals of narcotic users for the years 1921, 1922, and 1923, totaling 9,637 in number, I found that they represent 8,174 individual narcotic users. I then checked up the criminal records of these 8,174 persons, and so far as shown by records on file in the international identification bureau of narcotic criminals, of the New York police department, representing 700 cities and 27 nations, these 8,174 individuals had been previously arrested 32,696 times in all sections of the country for every crime on the calendar.

The 8,174 narcotic users were tabulated as follows:

Eight hundred and seventy-six opium smokers (mostly Chinese).

Twenty-seven hasheesh users (marahuanne smokers).

Three hundred and seventy-nine use morphine only.

Six thousand eight hundred and ninety-two use heroin separately or combined with cocaine.

It will be noted that, eliminating the smokers of opium and hasheesh, 95 per cent of the narcotic addicts use heroin. Only 2 per cent trace their addiction to medical reasons.

These figures are exact as far as criminal records were available, and are extremely illuminating on the great problems confronting the police. They permit us also to arrive at the definite conclusion that the number of drug addicts in the State of New York—estimates running to half a million individuals—has been grossly exaggerated.

We know there are drug addicts among the wealthy, in society, on the stage, and in the professional ranks, but their number has also been greatly overestimated. Some of these have also been arrested by the police. The source of supply of the drugs in these instances is the same—the smuggler and the street vendor.

(To be continued)

Valuable Facts in Orthodontia of Special Interest to the General Dentist*

By Samuel Herder, D.D.S., New York, N. Y.

Orthodontia has for its object the correction of the malocclusion of human teeth with all the manifold benefits resultant therefrom. Among these benefits may be mentioned the following:

1. The ability to masticate food properly.
2. The ability to speak more clearly and distinctly.
3. The ability to breathe properly, resulting in the inhalation of air which has been properly warmed and filtered rather than impure air which has not been transformed to the proper body temperature.
4. The prevention of a tendency toward pyorrhea alveolaris, due to the mechanical irritation of food debris, tartar, salivary calculus, etc., on account of the lack of the self-cleansing characteristic of irregular or malposed teeth.
5. The eradication of nervous and other disorders due to impacted or malposed teeth.
6. The prevention of dental caries due to the non-self-cleansing characteristic of irregular teeth.
7. The decided improvement not only of the physical characteristics of the face but of practically the entire body.
8. A decided improvement in health and mentality.
9. Finally, as a result of all the above-mentioned benefits, a decidedly improved change in the future career of the individual concerned.
10. Also, other benefits not mentioned here.

Orthodontia Neglected

Of the various branches of dentistry orthodontia seems to have received the least amount of attention or consideration at the hands of the average practicing dentist. It seems to be a characteristic of human nature to be prejudiced against a thing about which very little is known. In this connection it may be mentioned that ignorance of at least the general and basic principles of orthodontia lies at the root of the almost criminal neglect of patients suffering from various malocclusions of the teeth.

Although I do not like to venture the statement I feel that I owe it to the profession to say that there may be quite a number of dentists who withhold orthodontic advice from their patients—such as, referring

*Read before The Mount Royal Dental Society, Montreal, Quebec, November 9, 1923.

them, when orthodontic treatment is indicated, to a competent orthodontist—because of the fact that they may very often receive no appreciable amount of remuneration from their patients for such advice. In certain cases it is very often necessary to have the orthodontic work done *before* the construction of partial dentures needed in those cases. Would the average dentist refer such a patient to an orthodontist, assuming that he required at least one or more years for the orthodontic work? Would the average dentist risk the chance, however slight, of having his patient go elsewhere for the partial dentures, for example, on account of the comparatively long time which might be required for the orthodontic treatment, thereby extending the time in which the patient might select his dentist?

It is, of course, hardly probable that a patient will fail to appreciate the dentist's interest in his welfare when he strongly recommends the correction of his irregular teeth, with the manifold benefits accruing therefrom. Are there dentists who would deliberately overlook the recommendation of much-needed orthodontic treatment because of temporary financial loss in having to postpone the insertion of a partial denture? I leave the answer to you. However, we find here and there the unpleasant reptile of mere financial gain, as well as pressing economic conditions, thrusting out its vicious fangs, to the decided detriment of the patient concerned. Of course, there can be but one solution to this problem. The beast must be slain. The well-being of the patient must come before all else if the honor of the dental profession is to be maintained.

Normal Occlusion and Tooth Function

As one of their chief functions, human teeth may be considered as a tool for reducing the size of food preparatory to its reception into the stomach. If this tool is injured, can we expect to obtain the maximum amount of efficiency from it? If the teeth of a saw are bent, broken or in malposition, can we get the maximum amount of efficiency from it? The same may be said of the blades of a pair of shears, also of a finger or an arm which has been dislocated or malposed. In the two latter instances, besides the lack of efficiency, there is presented a distinctly unpleasant appearance.

The obvious and logical remedy for a dislocated finger or malposed teeth is similar, namely: the correction of the dislocation or malposition. It may be readily seen, therefore, why it is necessary that every practicing dentist not only should understand the distinct benefits derived from normal occlusion but especially should have a very good idea of what normal occlusion of human teeth really is. It is my candid opinion that no one is fitted to practice dentistry who does not

first have a clear understanding of the normal occlusion of human teeth, for it is my firm belief that the understanding of normal occlusion of human teeth is the foundation-rock upon which the entire profession of dentistry rests. Without it our dental institutions will crumble as easily and surely as a house of pasteboard cards after the casual kick of a passerby.

Why is normal occlusion so important? Simply because by it, and by it alone, can the maximum efficiency of human teeth be maintained. No dentist can possibly restore a patient's teeth to normal unless he first has a clear picture of what that normal ought to be. Just as the shape of each brick and the relation of the bricks in a given building to each other as to position determine the shape and construction of that building, so the shapes of the teeth in any given mouth and their relation to each other as to position determine the kind of occlusion in that mouth, whether normal or abnormal.

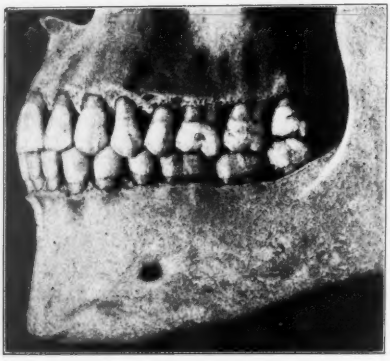

Fig. 1

An example of normal occlusion. Note the shapes of the teeth, indicating their function, and their relation to each other in occlusion.

The Shapes of the Teeth in Normal Occlusion Determine Their Function

The shapes of the teeth in normal occlusion determine their function. Thus it will be seen that the chisel-shaped incisors are for shearing; the single-cusped canines for tearing; the bicuspids for tearing and grinding; and the molars, simulating the mortar-and-pestle action, are chiefly for grinding up the food. (Fig. 1.) It must be seen, therefore, that in the treatment of any broken-down tooth it is absolutely necessary to restore it as nearly as possible to its original shape and contour if the maintenance of its normal function is desired.

Also, in the insertion of one or more artificial teeth in any given mouth the best result for that mouth can be had only when the nearest to normal occlusion for that particular mouth is obtained.

Since malocclusion of human teeth is more a common than a rare condition, the understanding on the part of the dentist of at least its general and basic principles becomes increasingly urgent. Since malocclusion is simply a deviation from normal occlusion and increases in direct proportion to the extent of that deviation, it can readily be seen that a clear understanding of normal occlusion will act as a very definite guide to the condition of the teeth as to occlusion.

In order, therefore, that the condition of normal occlusion may be more clearly understood, I have hit upon the following explanation. It is, of course, understood that the occlusal regions of only the crowns of the teeth are referred to here. It is necessary to consider only one half of the jaws, i.e., the jaws on only one side of the median line of the face, for what applies to one half of the jaws will apply also to the other symmetrical half. Beginning at the median line, therefore, we find in normal occlusion that the lower centrals and laterals are much smaller and narrower mesio-distally than the upper centrals and laterals. What is the result of this? It is simply this: all of the lower teeth except the lower central, which already approximates the median line, are brought forward mesially a distance equivalent to the difference between the combined widths, mesio-distally, of the upper incisors and the lower incisors. As a result of this, we find the position of the teeth in normal occlusion as follows (Fig. 1):

(a) The lower central, approximating the median line, will occlude with a little more than about one-half the width of the upper central.

(b) The lower lateral will occlude with the remaining distal part of the upper central and about the mesial half of the upper lateral. The point that I want to bring out is that the lower lateral is mesial to the upper lateral.

(c) The lower cuspid is mesial to the upper cuspid, the distal plane of the former occluding with the mesial plane of the latter.

(d) The lower first bicuspid is mesial to the upper first bicuspid, the distal plane of the former occluding with the mesial plane of the latter.

(e) The lower second bicuspid is mesial to the upper second bicuspid, occluding in a manner similar to that of the first bicuspid.

(f) The lower first molar is one-half of a cusp mesial to the upper first molar, the distal plane of the mesial cusp of the lower first molar occluding with the mesial plane of the mesial cusp of the upper first molar.

(g) The lower second molar also is one-half of a cusp mesial to the upper second molar, the mesio-buccal cusps occluding in a manner similar to that of the first molar.

(h) The lower third molar is one-half of a cusp mesial to the upper third molar, occluding in a manner similar to that of the first and second molars. These facts, together with the fact that all of the upper teeth, to a certain degree, lap over the lowers labially and buccally, give the average dentist a fairly good idea of what normal occlusion ought to be.

It may be in place to mention at this time that a poorly constructed filling or partial denture will very often seriously prevent proper tooth function and may result in a very pronounced condition of malocclusion.

133 West 72nd Street.

(*To be continued*)

Oral Sepsis—From the Viewpoint of the General Surgeon

By Willy Meyer, M.D., New York, N. Y.
Attending Surgeon, Lenox Hill Hospital, New York

(*Continued from September*)

Effect of Acid Reaction in the Mouth

I should not close the discussion of this subject with reference to protecting the health of older people without calling attention to one more important point—the effect of the frequently present *acid* reaction of septic teeth and gums. "Acid-bathed or acid-secreting surfaces are easily subject to cancerous change, while alkaline-bathed surfaces are much less liable to become involved. The infected mouth shows a tendency to acid reaction and it is through this acid change that we have an additional danger in cell degeneration of a malignant type from irritation."

In order to control the development of malignant disease of the mouth as much as possible, modern therapy must still more emphatically demand careful and extended treatment of patients suffering from oral sepsis. In one of his remarkable addresses before American Dental Associations Dr. Charles H. Mayo of Rochester, Minn., from whom a part of the last paragraph was quoted, wound up with the words: "The next great important step in preventive medicine should be taken by the dental profession. The question is, will they do it, will they make good?" He meant, will the profession of dentistry come forward and do this prophylactic work which is of such real importance, particularly for the growing generation?

Today we can unhesitatingly answer this question in the affirmative. The dental profession *has come forward* in great style. It is wide awake to its prophylactic mission. Whether its members call themselves D.D.S.'s or oral surgeons, they are all ready and willing and actively engaged in performing the required charitable work, as physicians, surgeons and specialists have done for many years. With this conception of his calling and his duties toward the public at large the dentist of today has become a close ally of the medical man.

Dentists in Hospitals

Hospitals of standing have created positions in which the dentist works hand in hand with the attending surgeon in the preparation, performance and after-treatment of difficult operations on the jaws and palate for malignant disease, in the proper handling of injuries, fractures, etc., involving the teeth. At the Lenox Hill Hospital of

this city internists and surgeons in their ward work have long made arrangements with their dental colleagues who work in the dispensary to visit, examine and treat regularly the patients entrusted to their care; the same is done in the Children's Division. For years it has been considered indispensable to prepare the mouth (that means teeth and gums) thoroughly before performing any operation on tongue, jaws or pharynx, just as, I am sure, is customary in other leading hospitals. At the present moment our Board of Trustees is considering a proposition from the Medical Board to create a properly endowed Dental Division within the hospital.

In order to do justice to the patients in the wards, some hospitals recently have commenced to have on the house staff a thoroughly trained and well-recommended young dentist, fresh from college, who attends to the regular cleansing of patients' teeth, thereby taking this time for routine work off the hands of the older and more experienced dental surgeon.

Is Pyorrhea Alveolaris Curable?

Naturally a number of important problems concerning the work of the dentist are still unsolved. I shall mention only pyorrhea alveolaris, the scourge of the mouth, the most obstinate and tormenting foe in otherwise seemingly healthy individuals. I do not know how many of you claim, or can claim, that you are able to cure it. I personally, in an active surgical practice of forty-two years, am still waiting to see the first case of a complete and lasting recovery from this trouble. And yet pyorrhea is considered to be one of the most frequent sources of focal infection throughout the human body, one that is and can be treated by the dentist only. It is, it seems to me, your solemn duty to make a united effort to learn to eradicate it in the individual case.

Use of the Elastic Neckband

Without for a moment intending to frighten you by stepping on the slippery surface of pyorrhea therapy I should like to mention here, from the point of view of the general surgeon, hyperemic treatment. This simple, almost universally neglected, and yet so wonderfully efficient therapeutic method could be employed in your specialty, principally in the shape of the elastic neckband. You will, I am sure, very frequently be amply remunerated for the initial necessity of closer observation of the patient thus treated by very quick and remarkable cures, not only in many inflammatory affections of the teeth, jaws and sinuses but, I venture to hope, perhaps also in pyorrhea alveolaris, the treatment being used, of course, in conjunction with all the means now in your hands for combating the disease, particularly the removal of calcareous deposits and neutralization of the usually present acid reac-

tion of the mouth. The elastic neckband—to be worn during the day, invisible, under the man's collar, and on the low-neck-gowned woman to be covered with a piece of velvet ribbon, and to be worn, of course, also during the night—will prove a faithful assistant to you in your efforts to fight off the fauna of pyogenic bacteria, and perhaps also the endameba buccalis seen in pyorrhea; and it will also aid in rendering innocuous, at least in part, their toxins, ever ready to flood the system.

Perhaps some of you are already employing this method. If so, it would be worth while, I think, if you would faithfully collect and publish your experience for the benefit of those who have not yet tried the treatment. It certainly would be gratifying if dentists in general would find in the elastic neckband the same powerful agent as surgeons have found in their daily therapeutic work. Naturally it is best employed as soon as the first signs of the disease appear. It would be a difficult task, I fear, to make a patient infected with a well-developed case of pyorrhea show sufficient patience and perseverance to wear the band for many months. *Very early* treatment—one might call it prophylactic treatment—must prove to be the most efficient. And should the patient get weary of wearing the band, let us remember that there are three ways of producing hyperemia.

The Two Other Methods of Hyperemic Treatment

Besides the elastic constriction, there is superheated air. Here, in the shape of the hot-air douche, a small-sized specimen is already in the dentist's hands for quickly drying the operating field in the course of an operation. The amount of heat produced is easily graded. And, further, we have suction, a magnificent arrangement for the production of artificial hyperemia. I have not a moment's doubt that with your great technical ingenuity you would soon invent and construct useful apparatus for this purpose. It could be made of glass, rubber or metal combined with rubber, fitting water-tight over the lower as well as upper jaw, and then, by means of suction, also easily graded, would produce this other type of hyperemia. Perhaps such apparatus is already on the market and in the hands of some of you. I do not know of it but should not be surprised if that were the case. With suction, after rough superficial cleansing of the gums, you would be able to suck off gradually the soft pyorrheal deposit and then go so far with it at each sitting that the gums begin to bleed, with the apparatus five minutes on and three minutes off, for six times, and at only one sitting for a day. The apparatus, after proper trial, could be given to the patient for self-application, just as in our cases. The procedure is easily taught.

With these three methods you could vary the treatment should the patient unwisely grow tired of the one ordered first.

Sterilization

These remarks on prophylaxis would be still more incomplete than they are already should I forget to mention another type of prophylaxis that is in your hands: the regular resterilization of instruments and hands in the course of your daily work. Never was I more impressed with the extent to which aseptic and antiseptic teaching has penetrated our country than when I visited a dentist's office in a small town a few years ago. There stood, easily reached and in view of the patient, a receptacle filled with boiling water on a small electric stove. It received all the instruments that had been in use, not only after each case but in the course of the treatment of every patient. After a few minutes the nurse regularly took the boiled instruments out with forceps, dropped them in cool sterile water and dried them ready for use by the surgeon. I am thoroughly aware, of course, that a great many of you are working with the same care and precaution as we have been for years, but I believe that this one link in the chain of antiseptic surgery has not yet been universally introduced into dentistry as a matter of self-understanding and necessity.

Use of Rubber Gloves

And regarding the wearing of sterilized rubber gloves in your work —why not? The inconvenience to the patient of the permanent touch with rubber-covered fingers would be outweighed by his knowledge of the absence of any possible contamination. And your own discomfort? It would be outweighed, I am sure, by the feeling of self-protection. To mention just one point—you rarely have the chance to take a Wassermann test, at least not at the time of your first examination, as we all do as a routine measure, always remembering of course that a negative Wassermann is of comparatively little significance for excluding syphilis definitely. What a satisfaction for you to know that you are secure against direct infection in a case of that type! Working with gloved hands is but a matter of habit and training. Must *we* not and do *we* not wear them in the most difficult and long-drawn-out operations? Does not the specialist for the nose, ear, throat, etc., do the same? Probably many of you use them today. It is such a simple matter for the nurse or attendant to boil, dry and powder the sets of gloves in the evening and thus let the surgeon feel that he will always be ready for the next day's work in up-to-date fashion. With your entrance into general medicine and surgery it might be advisable and profitable for all of you, it seems to me, to conform to generally adopted surgical rules. Of course, you will get tired at first, but a brief rest for the hands and arms between cases will also prove beneficial to your general health.

In conclusion, let me emphasize once more that the long-desired, important and absolutely necessary active coöperation of physicians or surgeons and dentists has at last become a reality. "Teamwork" by medical and dental specialists is the order of the day. May the dental profession be thoroughly conscious of its new dutles! May its members prepare themselves for their great new task early in their career, scientifically as well as practically, for the benefit of suffering mankind!

700 Madison Avenue.

The place, Dallas, Texas—The date, November 10-14, 1924—You will never regret going to this Meeting, as everything important to the Profession will be in evidence—A pleasant time of the year; good transportation, and accommodations to suit everybody—Let's go!

A Brief Survey of the Past Twenty-five Years in Dentistry

By C. E. Conley, D.D.S., LeSueur, Minn.

It is said that when a person begins to live in the past, he is truly old; so if we are to remain young, we must "keep ever burning before our vagrant step the kindly light of hope." And though we "come not within sight of the castles of our dreams," yet we must still keep alive and active those dreams and aspirations. We must have visions and imaginations, for he that is without dreams and visions of the future is truly lost. Therefore in this brief survey of the past twenty-five years in dentistry you will understand that I am not living in the past, but only looking backward that we may the better look forward.

During the past twenty-five years the dental profession has been exceeding the speed limit all the time, and during that time such a vast amount of useful, as well as useless, information has accumulated that men of ordinary intelligence are almost bewildered. We are a little dazed by the rapidity of the big events. I know of no profession that has made such revolutionary advancements. Not long ago a certain dentist of middle age went to a friend of mine and, with tears in his eyes, said, "I am through, I must quit, I cannot keep the pace." His health was good, and his mind was functioning, but the trouble with him was that he was not keeping up to the times.

The thing that makes dentistry *interesting* is the fact that something new is coming all the time. A few years ago a man could acquire about all the knowledge then extant in dentistry, but today it is utterly impossible for any one man, no matter how intelligent, to know it all. Some may try to convey that impression, but it only makes them ludicrous.

What, then, must be done? Answer: specialize. But to specialize properly you must have a thorough working knowledge of all branches of dentistry, for they are so correlated that one is interdependent upon the others. So even the specialist of today has a big task.

The whole world is overwhelmed with knowledge. An editorial in a reliable paper has this to say: "There is this obvious lesson—that education must come to deal more and more with doing rather than with knowing. The 19th century rated mere knowledge too high. The 20th century must effect an adjustment by which we shall train our habits and instincts of living to the highest possible efficiency and trouble ourselves much less with the barren way." That remedy can aptly be applied to dentistry. We must learn to deal more and more with doing rather than with mere knowledge. Of course, knowledge must precede doing, but the two must be proportionate.

It seems that some of our colleges are in great need of the aforesaid

adjustment. The tendency appears to be, in lengthening the course, to spend this added time mostly in theory. I believe we have enough theory and what we need in all colleges is more "doing," for knowledge is like faith in that "faith without works is dead." Dr. Buckley claims that there are too many inexperienced teachers in our colleges of today. The greatest school in the world is the school of experience, and experience coupled with good college training fits a man to give the highest and most efficient service as a teacher.

In gathering data for what follows I am indebted to Dr. Louis Ottofy of Chicago, who is editing a new dental directory, and also to the Bureau of Census at Washington, D. C. By far the greater portion of my information, however, is from Dr. Ottofy, and I believe his figures to be as reliable as any attainable at present.

The Bureau of Census gives the figures for only twenty years, from 1900 to 1920. In 1900 there were 29,665 dentists in the United States. In 1920 there were 56,152 dentists in the United States. This shows a gain in twenty years of 26,487, not quite 100 per cent. In 1900 the population of the United States was 75,994,575, with one dentist to 2,224 people. The population of the United States in 1920 was 105,710,620, with one dentist to 1,882 people.

During that time the number of dentists increased in proportion to the population, but the demands upon the dentist multiplied. The education of the public in the care of the teeth has been very rapid. The x-ray has opened up new fields and has greatly increased our responsibilities. The greater prevalence of caries, pyorrhea and nearly all oral infections has greatly added to the demands the public and the physicians are making upon the dentist.

Dr. Ottofy estimates that twenty-five years ago, or in 1899, there were about 28,500 dentists in the United States. And after a careful estimate he thinks that at present there are in the vicinity of 58,384 dentists in the United States. I believe the number is nearer 60,710—a little more than doubling in numbers during the past twenty-five years.

There seems to be a wide difference of opinion regarding the percentage of dentists that drop out of the profession each year, but we will confine ourselves to known figures, that is, from the years 1900 to 1920. The following figures are given to show the number of graduates during these twenty years, the number of dentists in 1920, losses during the twenty years and the percentage of such losses.

Number of dentists in 1920	29,665
Number graduated from 1900 to 1920	46,032
Total, if there had been no losses	75,697
Census of 1920	56,152
Losses in 20 years	19,545

Average graduated each year	2,301 plus
Average losses each year	977 plus
Making a yearly gain of	1,324 plus
Comparing the number graduated each year to the number dropped out, the percentage of losses	42½ per cent

It hardly seems reasonable that so many men drop out of our profession each year. It must be either very unhealthy or extremely disagreeable. Possibly some find it a little of both. At any rate, the figures show a loss that seems to me unreasonable. Dr. W. O. Talbot has an article in the Texas Journal for March, 1923, under the head, "Why Do More Men Leave the Dental Profession Yearly Than Enter It?" Such a heading reminds me of the old conundrum, "Why do married men live longer than single men? Ans.—They do not; it only seems longer." I do not know on what grounds Dr. Talbot makes this statement. But I do know it is erroneous. The work has increased so rapidly, and we have been so crowded for time, that I suppose Dr. Talbot took it for granted that our numbers were growing less.

In 1899 there were fifty-two dental colleges in the United States. In 1924 there are forty-three colleges, a loss of nine colleges in the twenty-five years. But the loss in quantity has more than been made up in quality. Not all the nine colleges went out of business, but we have had some very important consolidations, as follows:

The Southern Dental College and the Atlanta Dental College, forming the Atlanta-Southern Dental College.

The Kansas City Dental College and the Western Dental College, forming the Kansas City-Western Dental College.

The University of Maryland School of Dentistry and The Baltimore College of Dental Surgery.

The Baltimore College of Dental Surgery was the first dental college in the world and began its work in 1839.

To recapitulate—the last quarter of a century has seen our profession raised from one of mediocrity to one of prominence. We have more than doubled our numbers, and, while we have nine less colleges, it is safe to say that the forty-three we now have are far more efficient and effective than the fifty-two of twenty-five years ago.

The past quarter of this century has been the most important period in the history of the dental profession, especially the last ten or fifteen years. During this latter period its advance has been spectacular.

The old barriers between the medical and dental professions are fast disappearing, and today, as never before, we are combining to prevent as well as to overcome disease.

The entrance requirements to all our dental colleges are very much

higher than formerly. The standards all along the line are moving upward. The years of study are constantly growing longer, and the whole tendency is for higher and better dental education, thereby making for more efficient dentists.

The future holds great possibilities for our profession. Our sun is rising, and we must "put on the full armor" and make the best of our endowments, governed by conscience, with a will to do our part to the best of our ability, inspired by the example of such noble men as Dr. C. N. Johnson, Dr. Truman Brophy, the late Dr. G. V. Black and many others, not quite so much concerned with the "almighty dollar" but rather governed by a desire to render the very highest service possible, and living and working under that greatest of all rules, "Do unto others as you would have others do unto you."

A New Dental Course

A new departure in dental educational circles will be initiated by Marquette University College of Dentistry at Milwaukee, Wisconsin, in 1925, when a five-year course, including two years of prescribed liberal arts work and three years of dental study, will be introduced.

This was the announcement by the Rev. Albert C. Fox, S.J., president of Marquette, who pointed out that this coming school year would be the last in which students could enter the College of Dentistry and go through the complete course in four years as has been the case in the past. The change has been approved by the Board of Trustees of the University.

In taking this step, Father Fox said, Marquette was assuming the lead in a matter of policy to which all Class A dental schools must conform by 1926. In doing so, it is following a decree of the Dental Educational Council of America, which desires to elevate the standards of dental education to the plane already maintained by medical and legal educators.

Under the plan to be introduced next year the pre-dental course of two years will include courses in inorganic and organic chemistry, physics, biology, English and a foreign language. The dental course proper will cover three years. At the end of the fourth year of work students who took their pre-dental work at Marquette will receive the degree of Bachelor of Science, while at the end of the fifth and last year they will be given the degree of Doctor of Dental Surgery.

Among the advantages of this new plan, it is pointed out, is that the pre-dental and pre-medical courses at Marquette will be similar and that after the first two years of work a student may elect dentistry

or medicine as his profession. Many instances are known where a student has taken a year or two in the dental college and then transferred to medicine, or vice versa, and this will be eliminated to a large extent.

"Marquette University is setting an example in introducing the two-year pre-dental course," said Dr. Henry L. Banzhaf, dean of the College of Dentistry, in commenting on the change. "Other institutions have expressed approval of the plan, and practically all the leading dental colleges will adopt it sooner or later."

Announcement is also made of the establishment at Marquette University of the world's first graduate school of dentistry, giving the degrees of Bachelor of Science in dentistry and Master of Science in dentistry. There will be four separate and distinct courses, including oral surgery, orthodontia, prosthetic dentistry and preventive dentistry. Each course will cover two semesters and will require the entire attention of the students.

The Marquette graduate course can be regarded as a step forward in dental education and, according to Dean Banzhaf, it is the realization of one of his life's ambitions. It has been started to answer a demand from practicing dentists for complete courses that will allow them to specialize instead of to review undergraduate work.

The Relationship of the Nose and Throat to the Teeth—Their Permanent Preservation

By Charles Gluck, M.D., New York, N. Y.

(*Continued from September*)

A nose and throat, to be considered perfectly normal nowadays, must possess absolutely the following conditions, all dependent on a perfectly normal Waldeyer's ring and normal nasal accessory sinuses and on the ability of the body to seize the necessary amount of oxygen.

1. It is necessary that faucial tonsils be completely removed. The writer maintains and firmly believes that the tonsils cannot, under our present community life in our present state of civilization, remain normal. All faucial tonsils are diseased. This is absolutely unavoidable under present living conditions. In every individual case they must invariably become and remain infected, and in most cases they become infected early in the person's career—in the earliest infancy, in fact—and remain so throughout life.

2. It is also essential for the general and special welfare of the individual that the lingual tonsils be absent; or at least that only the smallest amount of lingual tonsillar tissue be present.

3. It is essential that there be no visible lymphoid or follicular tissue about the throat proper (pharynx).

4. It is important that there be no adenoid tissue of any appreciable amount in the nasopharynx. This should be equally true of all adhesion bands and lymphoid tissue so commonly found in the vault of the pharynx.

5. It is essential that there be in the nasal fossae a straight and thin nasal septum. This implies that all deflections, ridges, spurs, thickenings, etc., of the nasal septum, if present, be removed; likewise, that no other normal tissues be removed, and that no other foreign tissues be present in the nasal fossae such as polypi, new growths, etc.

6. It is necessary that the middle and inferior turbinates be of normal size, that they hang freely in the nasal fossae, and that none of them touch the external wall of the nose or the nasal septum. This is especially true of the middle turbinates, particularly that they be of normal thinness, and the lower edges of the inferior turbinates should not come too far down, too close to the floor of the nose; that is, they must be a normal distance above the floor of the nose. Their lower margins should be at least 3/16 inch above the floor of the nose.

7. The presence of normal accessory nasal sinuses is essential.

These seven conditions would presuppose normal accessory nasal sinuses. For the average case abnormal conditions of the accessory sinuses could not exist very long in the presence of these conditions. The average case of sinusitis cannot persist very long after the institution of such perfect normality of the nose and throat as required by these conditions. With few exceptions the sinuses would automatically be freed of all diseases as a natural result of the institution of such absolutely normal conditions.

A perfectly normal state of all the nasal accessory sinuses is the last, and far from the least, of the important conditions required to constitute a normal nose and throat as defined.

The foregoing is my definition of a perfectly normal nose and throat, and I feel quite sure this will be accepted ultimately by both professions as a prerequisite to good health in general and good teeth in particular. Hence it can readily be seen that the conscientious dentist will more and more have to reckon with the nose and throat to overcome diseased conditions of the teeth and gums, and especially in order to bring about a permanent state of dental health. To obtain lasting results, he will be compelled to insist on a normal nose and throat as already defined. He will have to learn that the explanation for his failures lies in the nose and throat. Therein will he find the reason for the decaying teeth, the persistent recurring pyorrhea, and most of his other dental troubles. The dentist who finds great difficulty in keeping the teeth of an individual from decaying over a period of years or in curing the common chronic forms of pyorrhea will have to look to the nose and throat for the explanation, and also for the means to help him accomplish the desired end.

Innumerable teeth have been sacrificed from earliest infancy as much by actual decay as by extraction, due to the general failure on the part of the dental and medical professions to look to the nose and throat for the general cause.

The number of plates will disappear in direct proportion to the number of nasal cavities and upper, middle and lower throats and bases of tongues that have been rendered normal sufficiently early.

It is not to be forgotten that, thanks to abnormalities of the nose and throat, we have such interesting teeth conditions. The abnormalities under discussion give birth to these conditions and make possible their breeding to full maturity. Frequently, after destruction and disease of the teeth and gums have been fully developed, it would appear, upon looking into the nose and throat, that the latter were perfectly harmless and innocent of the production of such trouble to the dental organs. The medical man frequently meets an interesting phase of the injurious results that a defective nose and throat produce on the teeth in people past middle age. This consists of vague but nevertheless extremely painful neuralgia affecting usually one locality

of the face or head or both. Focal abscesses are invariably found in these cases, either in the apices of the teeth or even in cases of osteomyelitis of the jaw-bone; pyorrhea is always present, as well as unextracted root remnants and foul, fetid breath. Attention to these factors promptly relieves the neuralgia. The following are two cases which are typical of the idea that the nose and throat defects produce disease of the gums and teeth which in turn give rise to other troubles; that is, they prove conclusively that, without preceding and coexisting nose and throat trouble, the teeth and gums would never have reached a state of disease.

Case 1: Mr. G., aged 55 years. Severe neuralgic pains of entire left half of head, starting at the anterior area of jaw, and left side of neck, traveling upward to vertex. Usual nose and throat abnormalities present. Teeth in a deplorable condition. Multiple abscesses surrounding left upper canine and molars. Mouth odor repellant. Nose and throat abnormalities present were corrected as outlined above. Also correction advised of condition of teeth and gums. Neuralgia disappeared.

Case 2: Mr. S., aged 56 years. Typical tic douloureux pains, lancinating sometimes continuously. Mouth odor abominable. X-ray showed osteomyelitis of upper right jaw-bone, involving all tooth sockets of right anterior quadrant. This area was treated surgically. Usual nose and throat attention. Pains gradually completely disappeared.

Today the pendulum is swinging the other way. Not so many teeth are being sacrificed as in previous years. This is only as it should be. Teeth once extracted cannot be replaced. With all due credit to the marvelous advances of the dental science, artificial teeth do not equal one's own good teeth. Only teeth whose apices are surrounded by irremediable abscessed tissue should be sacrificed. The more attention given to the nose and throat, the fewer teeth will be sacrificed.

Pyorrhea, of course, is rightly considered hopeless, incurable, as a disease in itself; that is, if we undertake to cure simply the pyorrhea. The explanation for this is that the pyorrhea is dependent for its existence, persistence or recurrences on abnormalities of the nose and throat primarily. The foundation for these conditions is laid in abnormalities to be found in the nose and throat, such as previously described, and unless these are eradicated simultaneously with any method of cure for the pyorrhea proper, relapses must surely reoccur. Unless the factors which make its existence possible are likewise destroyed, the pyorrhea must return. Hence pyorrhea can never be controlled permanently or cured unless the abnormalities of the nose and throat which are invariably present are corrected. After that it becomes a very simple matter. The teeth rapidly become firm and immovable under the simplest treatment of the gums. The gums heal rapidly,

the discharge and accumulation disappear. It is high time that the dentist considered this situation from the standpoint of the nose and throat—the common foundation of good health. And when he does go about seeking a cure in this manner he will then obtain permanent results—and not until then!

There is nothing sadder in my daily experience than the frequent appearance of toothless or almost toothless middle-aged men or women, and, also, for that matter, young men or women. Is there anything more depressing than to watch these numerous people remove their plates of false teeth preparatory to treatment? In such cases I have never failed to find the presence of one or more abnormalities of the nose and throat. This, in my opinion, is without doubt the explanation for the toothless or almost toothless condition of so many individuals. How simple a matter it would have been to save all these teeth by placing the nose and throat of such patients in a normal condition during their earlier years!

Right here one of the greatest curses that the evil effects of modern civilization have imposed on the individual shows itself; and that is mouth-breathing. Of all influences that man meets or is subjected to, none has a greater power for destruction of his teeth than mouth-breathing. Mouth-breathing is caused by nose and throat abnormalities. Mouth-breathing is automatically destroyed by the removal of the one or more nose and throat abnormalities that instigated it and can be stopped *only* in this manner. In mouth-breathers the tooth enamel is constantly being injured. The growths of germs and other microorganisms which inhabit the mouth seem to flourish more readily between the teeth and in the crevices of the gums in mouth-breathers than in non-mouth-breathers. The continual postnasal discharge and nasal catarrhal and often purulent droppings, which are likewise produced by the same nose and throat abnormalities, keep setting up a constant and continual decaying process of the teeth, ending only in their destruction.

This old-time question of mouth-breathing is one of paramount importance in every discussion relative to preservation of the teeth. So many of our able medical men do not realize the pernicious effect of mouth-breathing on the general organism and its particularly evil effect on good teeth and gums. They do not comprehend that mouth-breathing is an abnormal process caused by the pathological condition of the nose and throat. These pathological factors are the ones previously described under the everyday abnormalities to be found in the nose and throat. The point of prime importance to be remembered is that as soon as these abnormalities of the nose and throat are removed the individual then automatically breathes through his nose only. In other words, mouth-breathing is an automatic process caused by a general series of profound degeneracies consisting of the crooked and

warped nasal septum and other interior structures of the nose and diseased lymphoid tissue, especially the tonsils, all brought about by the slow, continuous poisoning of the human body by toxins, filth, dirt and the general evils of civilization, such as vitiated atmosphere, etc.

Hence disease of the teeth and gums is a decaying process. The degenerative changes are caused by the multitudinous focal infections in and about the gums and tooth sockets. This entire matter is brought about as already explained. A favorable condition of the mouth and general organism must be present in order to permit infection of the gums and decay of the teeth.

Once disease of the teeth has been instituted, originated or brought about, we have a retro-active condition, or what is commonly known as a vicious cycle. That is, any disease of the teeth or gums will increase or maintain disease of distant organs of the body. The greater the disease or the abnormality of the nose and throat, the greater the amount or degree of disease of the gums and teeth; and the more of the latter, the more trouble we shall find in the nose and throat or remote organs of the body. Again, we have here a vicious cycle that can be broken with extreme ease. That the teeth are not the primary origin of this vicious cycle is proved by pointing out that in infants and very young children we find as yet no disease of the teeth or gums, but do find our greatest volume of nose and throat disease.

The greatest favor the dentist can confer on patients presenting difficult dental cases is to suggest and even *insist* upon tonsil removal and, if necessary, reconstruction of the remainder of the nose and throat. This, the dentist will find, will be his principal aid. This will make possible the cure of pyorrhea, retard further decay ordinarily, and will be the first step toward proper fundamental healing of the gums, tooth-socket tissue and the bony structure of the tooth sockets and jaw-bones, and, in fact, will control almost all of their dental ailments and bring the decay to a stop, especially the process of rapid decay. This discouraging process of decay will not cease until the patient is in possession of a normal nose and throat. This process of decay will continue until the patient has lost most, if not all, of the teeth, if the advice here given is not followed.

Disease of the teeth and gums, then, is a decaying process, and the degenerative changes are produced by multitudinous focal infections. As stated before, a favorable condition of the mouth and general organism must be present in order to permit the decaying of teeth and infection of the gums. This favorable condition for the destruction of the teeth originates principally in a faulty mechanism of the nose and throat. There are present in the nose and throat such abnormalities as allow disease to originate and grow in the mouth. Also, one of the

most extensive and commonest abnormalities is mouth-breathing. In its presence good teeth cannot exist or continue to exist. Hence, if anyone wishes to retain his teeth, let him see to it that his nose and throat are normal and free from all the common defects mentioned above.

It is easy to comprehend why the teeth suffer first and foremost of all the organs of the body. They are nearest the destructive influences of the pathological factors which are the nose and throat abnormalities. The teeth are most easily subjected to the two most important principles of inflammation—contiguity and continuity. That the teeth suffer most, as a result of disease of the nose and throat, is quite evident when one considers the great number of dental specialists who have developed as a result of the evil effect that a bad nose and throat have on the teeth.

As I have already remarked, the pendulum is rapidly swinging the other way. We are today removing fewer teeth than ever. We look back with remorse and chagrin on the enormous number of teeth that have been uselessly sacrificed. The moment a tooth is removed its absence is felt. This we know. There is no doubt about it. However, we have no definite proof that removed tonsils are ever missed. According to our best knowledge and most accurate scientific judgment, we have no definite facts compelling us to believe that any harm has been done by the removal of tonsillar tissue. On the contrary, wherever this removal has been successfully performed we invariably find that untold and immeasurable good has accrued to the individual. Normalizing the nose and all its interior and adjacent tissues and structures is logically a step in the right direction.

Hence the matter simmers down to this: spare the teeth, since they are physiological structures with which we cannot dispense. To accomplish this, normalize the body, commencing with the nose and throat.

Summarizing, there are two important facts that the dental profession will have to accept:

(1) Our most powerful instrument for curative effects on diseased teeth, gums, tooth sockets and surrounding dental tissue is to be found in normalizing the nose and throat.

(2) The greatest means at our command for the prevention of tooth decay, gum and tooth-socket and adjacent bony structure disease, as well as loss of teeth, lies in the nose and throat and is dependent upon the removal of the faucial tonsils, the institution of a straight nasal septum, and the accessory factors that affect these two fundamentals.

666 Madison Avenue.

AMERICAN DENTAL ASSOCIATION

Sixty-sixth Annual Session—Dallas, Texas
November 10, 11, 12, 13, 14, 1924

OFFICIAL CALL

To the Officers, Members, and Constituent Societies of the American Dental Association:

You are hereby notified that the Sixty-sixth Annual Session of the American Dental Association will be held at Dallas, Texas, on November 10, 11, 12, 13, 14, 1924.

The House of Delegates will convene at 10:00 o'clock in the forenoon and at 2:30 o'clock in the afternoon, Monday, November 10, 1924, in the Assembly Room of the Art Gallery, Dallas, Texas. All subsequent meetings of the House of Delegates will be held in the same place.

The general meeting, which constitutes the opening exercises of the Session, will be held on Tuesday, November 11, 1924, at 10:30 A. M. in the Convention and Exhibit Hall, Dallas, Texas, and general meetings will be held at 8:00 P. M. on that and subsequent days of the Session.

The various sections of the American Dental Association will meet Tuesday, November 11, 1924, at 2:00 o'clock P. M. and thereafter according to their respective programs.

The Registration Department will be open from 8:30 o'clock A. M. until 5:00 o'clock P. M. on Monday, Tuesday, Wednesday, and Thursday, November 10, 11, 12, and 13, and from 8:30 A. M. to 10:00 A. M. on Friday, November 14, at the entrance of the Convention and Exhibit Hall, Dallas, Texas.

The constituent societies are hereby notified to file with the General Secretary of this Association, at least thirty (30) days prior to the first day of said Annual Session, a list of names and addresses of their delegates and alternates.

WM. A. GIFFEN, *President.*
OTTO U. KING, *Secretary.*

A Home-made Artificial Bridge

By Percival S. Sprinz, D.D.S., New York, N. Y.
Oral Surgeon and Chief of the Dental and Oral Surgery Depts., Hospital for Joint Diseases, New York.

In my long experience in surgical work the enclosed cut is the first example of clever home-made dental work and shows the ingenuity of laymen in self-dental treatment. The patient, a Miss H., was referred to me by her dentist for surgical and pyorrhea work.

As she is a nurse by profession, she found herself so busy that it was impossible for her to have proper dental attention. The two lower centrals became so loose that she extracted them herself, but the space

looked so badly to her that she had to use her womanly ingenuity to improve the defect. She told me she took a piece of a rubber eraser and carved it in her spare moments, fitting it from time to time to her mouth. In order to hold it in place, she ligatured the two laterals with floss silk.

She made an exceedingly good job of it as the artificial bridge stayed in her mouth for several months and remained tight even after continued eating. The extraction of the two laterals was necessary in this case, due to the great amount of absorption around the roots. Her other teeth are now under treatment; prognosis is good.

574 West End Avenue.

Rules Defining Unprofessional Conduct as a Guide in the Administration of the Law

By The University of the State of New York, State Board of Dental Examiners, Albany

The Board of Regents at its meeting on June 26, 1924, adopted the following rules, defining unprofessional conduct, as a guide in the administration of the law.

1. Advertising personal superiority or ability to perform services in a superior manner.

2. Advertising definite, fixed prices that, in the nature of the professional service rendered, must be variable.

3. Advertising statements that might be calculated to deceive or mislead the public.

4. Employing, associating with or making use of advertising solicitors or free publicity press agents.

5. Advertising either by sign or printed advertisement under the name of a corporation, company, association, parlor or trade name, except that legally incorporated dental corporations existing and in operation prior to January 1, 1916, may continue so operating, while conforming to the provisions of this act. (Subdivision 4 of section 203 of the public health law, as amended by chapter 129 of the Laws of 1916.)

6. No corporation shall display any sign or advertisement concerning its work by the use of any name except its true corporate name and the names of the duly licensed dentists practising in connection therewith. It shall not use any parlor or trade name in connection with such corporate name, or display any sign or advertisement, any parlor, trade or assumed name under which the business was formerly conducted, except its true corporate name.

Any violation of these rules shall be deemed unprofessional conduct within the meaning of section 201, subdivision 2, of the public health law as applied to dentistry.

MINOR J. TERRY, D.D.S., *Secretary.*

Summary of Report Entitled "Community Oral Hygiene"

The latest in the series of public health studies to be issued by the New York Association for Improving the Condition of the Poor is "Community Oral Hygiene," this being a four-year report of a demonstration which the A. I. C. P. has been conducting in the Mulberry district of New York City. In a foreword to the report, Bailey B. Burritt, General Director of the Association, says:

"Communities are only beginning to awaken to their responsibility of providing a complete preventive dental program for school children. New York City in common with most communities has lagged behind Bridgeport, Boston and Rochester in providing an extensive dental service for school children. In order to promote this important work, the A. I. C. P. has undertaken an experiment in an oral hygiene program for the children in the Mulberry district in the hope that the results of this experiment might lead New York City and other communities to provide an adequate dental service for school children on a permanent basis."

The report, which was prepared by J. C. Gebhart, Director of the A. I. C. P.'s Department of Social Welfare, points out that it was agreed at the outset that such a demonstration would be most significant if it were confined to children, particularly those of the younger ages, and if the emphasis were placed upon educational and prophylactic work. In general, the policy has been to adopt those features of the work in Bridgeport and Rochester which were suited to the situation in the Mulberry district.

The following steps, arranged in the order of their relative importance, were deemed essential to the program:

1. Prophylactic cleanings at least once a year, and twice a year if possible, for all children in the first five grades of school.
2. Extraction of unsavable and diseased teeth, to put the mouth in a hygienic condition.
3. Prophylactic fillings (to prevent decay) in all first permanent molars and reparative fillings where needed in first molars.
4. Nitrate of silver treatment to arrest decay in deciduous teeth which are retained longest.

The fourth point, that of providing nitrate of silver treatment for temporary teeth, was added later after experience had clearly demonstrated that the treatment of the decayed surfaces of such teeth with nitrate of silver was sufficient to arrest decay and to enable the children to retain them for the proper length of time without imposing the

unwarranted expense of placing permanent fillings in teeth about to be shed. While the procedure outlined above was drawn up primarily for school children it has been followed also in the work with children of pre-school age.

The work was first begun October 1, 1919, in one of the public schools of the district with a full-time dental hygienist installed in the kindergarten room. In January following, a dentist was secured on half time. By June, 1920, this work had developed to such a point that a well-trained dentist with broad vision and executive ability was needed to develop the work along sound lines and to keep the staff inspired in their task. Besides the supervisor the staff now consists of two full-time dentists and two half-time dental hygienists.

The plan has been to concentrate efforts in the schools where no work has been done and where work may go on from year to year without interruption. In this way there was definite assurance that the work was being done where it was most needed and where the continuity of the service would enable the A. I. C. P. to secure tangible results.

An extension of the service to pregnant women was begun in February, 1922. The purpose of the experiment was to select a limited number of pregnant mothers, preferably those who were experiencing their first pregnancy, for intensive dental care and instruction in diet and oral hygiene. In this way it was hoped that the mothers would be encouraged to begin early in training their children in the care of the mouth.

The actual improvement in mouth conditions is best shown in the annual survey made by the A. I. C. P.'s supervisor for the purpose of determining in advance the amount of work needed during the year. The children are classified as to those needing extractions and fillings of various kinds and those who need no reparative work. Since the survey is not made at exactly the same date each year, obviously this picture is not altogether reliable; for if the survey is made quite early in the school year, before much work has been undertaken, a much less favorable picture is given than if made later, after many of the worst conditions have been cleared up. In spite of these variations, however, the annual classification of the children shows a steady improvement.

The A. I. C. P. has now made four annual surveys of the mouth conditions of the children of Public School 106, where the most intensive campaign has been conducted. The increase in those needing no corrective dental work and in those awarded diplomas for having kept their mouths clean has steadily increased. There has also been a marked reduction (from 85.4% to 46.4%) in children requiring fillings, for the most part in first permanent molars. While the propor-

tion needing fillings is slightly greater than last year, the proportion needing extractions has been reduced from 40.3% to 32%. This is again a most encouraging sign, for it means that more children have savable teeth than last year, and for such, fillings rather than extractions are indicated. There is also direct evidence that the fillings required are of a far less extensive nature than when the work first began, for in 1920 60% of the fillings were urgent, while in 1923 only 37% were urgent.

While approximately 3,000 children have been served annually through the dental clinics, approximately 1,200 of this number received intensive care, including extractions, fillings and nitrate of silver treatment. Obviously, the per capita cost for these 1,200 will be much higher than the per capita cost of the total 3,000 served. The practice has been to divide the total annual expenditures by the total number of children reached to secure the gross per capita cost. Thus, for the first year that complete records were available the gross per capita cost was $4.17. This item, however, included several expenditures for equipment and educational literature. By the following year the per capita cost had been reduced to $3.79.

The reduction in cost is due both to an actual decrease in the amount of corrective work to be done and also to the fact that a larger number of children were reached through the prophylactic service, where the cost is less. During the last year the per capita cost had increased to $3.99. This increase is due in part to extending the service to pre-school children, which at first involved considerable loss of time because of unkept appointments. It seems reasonable to conclude that a dental service of this kind costs approximately $4.00 per child reached. The A. I. C. P. also presents in its report the approximate average cost of particular operations, prophylactic cleanings, fillings, extractions and nitrate of silver treatments.

There are, indeed, few health services, the report points out, which for an average annual per capita expenditure of $4.00 can show such unequivocal and far-reaching results as those accomplished by this demonstration. The full implications of these results will not be fully realized until oral hygiene is accorded its proper place in preventive medicine. The increase in clean, healthy mouths, the saving of first permanent molars and the reduction in the incidence of dental caries have proceeded during these four years at a rate little dreamed of when the work was begun.

The demonstration has proved that a dental service which is administered as an integral part of the daily school program produces the most widespread and lasting results. Experience has shown that when the dental clinic is in the school building children can be sent directly from the classroom to the dental clinic with a minimum of waste time

both for pupil and operator and with a minimum amount of confusion and disruption of classroom work. The hearty support and cooperation of the school officials in promoting the educational aspects of the dental program could hardly have been secured if the dental clinic had not been in the school building.

The Dental Directory

The publishers of Polk's Dental Register advise us that the replies to 65,000 questionnaires mailed by them (presumably reaching every dentist in the United States and Canada) are not yet sufficient to assure that completeness and accuracy which they are determined to attain. At the time of reporting to us, only slightly in excess of 25 per cent of the replies have been received. The failure to send in *your* name may indicate the presence of only a small number of dentists in your city or town and thus mislead those who desire to change location, or who are establishing themselves in practice, to select your city or town, which may already have all the dentists it requires.

With the vast number of changes in location it is impossible to compile a complete list of dentists without *your* personal cooperation. Many seem to think that because their address is the same now as it was in the 1917 edition of the Register it is not necessary to reply to the questionnaire. This is a grave error. Unless *you* will reply or send in your name, it must be assumed that you are no longer in practice.

We desire to call your earnest attention to this important matter. It takes but a few moments to send in your name. Do it now! The members of the profession should realize that an accurate dental directory is an urgent requirement, and that its completeness depends on each individual dentist. The publishers are sparing no expense in time or money. They have secured every name from every possible source. But many of the letters are returned endorsed "Not there," "Moved," "Left no address," "Not known," "Not found," etc. If you have not sent in your questionnaire, please send it at once. If you have not received one, please send your name and address to the publishers (R. L. Polk & Co., 536 South Clark Street, Chicago), without delay.

Report of Committee on Exhibits

The building in which the American Dental Association will hold its meeting in Dallas, November 10-14, 1924, was built by the manufacturers of Dallas in order that they could hold exhibitions of their goods, and the spaces are all built in ready for the exhibitors of dental goods to unpack their products and place them in position for the members of the American Dental Association to inspect.

In fact, the Committee on Exhibits could be ready on one week's notice to put on exhibition the largest, finest and most representative exhibit of dental goods that has ever been held in the South.

From the exhibitor's standpoint, this meeting will give them the best opportunity that they have ever had, in that everything about this meeting will be held under one roof and the members will be on one floor, to attend the lectures, clinics and exhibits, passing from one to the other at will; hence, it will put the exhibitors in touch with the members at all times, and the section chairmen will have to hustle or the exhibitors will hold the audience.

Another thing that will make this exhibition especially attractive for exhibitors is that it is a virgin field, and no such exhibition as this one has ever been held in this section; therefore, about 2,000 will be in attendance from this section, very few of whom have ever attended a national meeting. These men will be eager to see the new appliances, instruments and materials.

The Committee on Exhibits has no hesitancy in saying that the exhibits this year will be one of the main attractions of the American Dental Association meeting, for so many exhibitors have engaged space that success is assured.

The Committee on Exhibits will be in constant attendance during the meeting to assist the exhibitors, and also to help the members take advantage of this wonderful opportunity.

The following exhibitors have reserved from one to four spaces:

LIST OF EXHIBITORS

The Abbott Laboratories, Chicago, Ill.

The American Cabinet Co., Two Rivers, Wis.

W. V.-B. Ames Co., Fremont, Ohio.

Becton, Dickinson & Co., Rutherford, N. J.

Henry P. Boos, Minneapolis, Minn.

Harry J. Bosworth Co., Chicago, Ill.

Bristol-Myers Co., New York, N. Y.

Burns Dental Casting Machine Co., Flushing, L. I., N. Y.

Cameron Surgical Specialty Co., Chicago, Ill.

Castle, Wilmot, Co., Rochester, N. Y.

The L. D. Caulk Company, Milford, Del.

Cleveland Dental Mfg. Co., Cleveland, Ohio.

Colgate & Co., New York, N. Y.

Columbus Dental Mfg. Co., Columbus, Ohio.

Cook Laboratories, Chicago, Ill.

Corega Chemical Co., Cleveland, Ohio.
Dental Products Co., Chicago, Ill.
Dental Specialty Co., Denver, Colo.
The Dentists' Supply Co., New York, N. Y.
Detroit Dental Mfg. Co., Detroit, Mich.
Dresch Laboratories Co., Toledo, Ohio.
August E. Drucker Co., San Francisco, Calif.
Eastman Kodak Co., Rochester, N. Y.
Florence Mfg. Co., Florence, Mass.
Flossy Dental Mfg. Co., Evanston, Ill.
Friedman Specialty Co., Chicago, Ill.
Hanovia Chemical Co., Newark, N. J.
The Heidbrink Co., Minneapolis, Minn.
Horlick's Malted Milk Co., Racine, Wis.
J. F. Jelenko & Co., New York, N. Y.
Johnson & Johnson, New Brunswick, N. J.
Kansas City Oxygen-Gas Co., Kansas City, Mo.
The Kolynos Co., New Haven, Conn.
Lambert Pharmacal Co., St. Louis, Mo.
H. R. Lathrop & Co., New York, N. Y.
Lavoris Chemical Co., Minneapolis, Minn.
Lea & Febiger, Philadelphia, Pa.
Lehn & Fink, Inc., New York, N. Y.
Medical Protective Co., Fort Wayne, Ind.
Metcalf & Thomas, Ft. Worth, Texas.
H. A. Metz Laboratories, New York, N. Y.
Mizzy, Inc., New York, N. Y.
E. C. Miller Co., Williamsport, Pa.
C. V. Mosby Co., St. Louis, Mo.
Mynol Chemical Co., Philadelphia, Pa.
J. M. Ney Co., Hartford, Conn.
The Pelton & Crane Co., Detroit, Mich.
The Pepsodent Co., Chicago, Ill.
Chas. H. Phillips Chemical Co., New York, N. Y.
Poloris Co., Inc., New York, N. Y.
Ransom & Randolph, Toledo, Ohio.
Ritter Dental Mfg. Co., Rochester, N. Y.
Lee S. Smith & Son, Pittsburgh, Pa.
Spyco Smelting & Refining Co., Minneapolis, Minn.
E. R. Squibb & Sons, New York, N. Y.
Sterile Products Co., San Diego, Calif.
I. Stern & Co., New York, N. Y.
Toledo Dental Supply Co., Toledo, Ohio.
Toledo Technical Appliance Co., Toledo, Ohio.
Victor X-Ray Corporation, Chicago, Ill.
Wappler Electric Co., Inc., Long Island City, N. Y.
S. S. White Dental Mfg. Co., Philadelphia, Pa.
H. B. Wiggins Sons, Bloomfield, N. J.
The Wilkinson Co., Santa Monica, Calif.
Wilmot Castle Co., Rochester, N. Y.

DENTAL LAWS

Summary of Dental License Requirements Throughout The World

By Alphonso Irwin, D.D.S., Camden, N. J.

MISSISSIPPI, U. S. A.

The dental laws are dated 1882, 1886, 1892, 1904, 1906, 1912, 1913, 1922.

The Board of Dental Examiners consists of: President, A. E. Russell, Oxford; Secretary, B. J. Marshall, Marks, Miss.; H. D. Vardaman, Rosedale; John H. Chapman, Columbia; H. J. Arledge, Poplarville, Mississippi.

The English language, dental supervision, examination and registration are required.

Examinations are held in the new Capitol Building at Jackson, the third Tuesday in June; examination fee $25.00.

Applications by dentists and dental hygienists should reach the Secretary ten days before the meeting.

Rules of the Mississippi Board of Dental Examiners

1. Examinations will commence promptly at 9.30 A. M. each day, and continue until all applicants have been examined. Reasonable time will be granted on each subject.
2. Applicants will not be permitted to leave the rooms during examinations.
3. Applicants are required to take the entire examinations or no credit will be given.
4. Assistance or help of any description, either given or received, will be penalized by forfeiture of fee and the privilege of continued examination.
5. Questions must be turned in with papers on each subject.
6. All papers should be folded twice so that the name of the subject and that of applicant may be written by him on upper margin and plainly shown.

7. Applicants must furnish engines, instruments, materials and patient for practical procedures.

8. Temporary licenses must be surrendered to the Secretary prior to entrance to examinations for permanent license.

9. A general average grade of 75 per cent is required on the entire examinations for acceptance.

10. A grade of 40 per cent or less on any one subject will constitute rejection.

For further information and blanks address B. J. Marshall, Secretary, 6 and 7 Turner-Cox Bldg., Marks, Miss.

Mississippi Dental Law

An Act to amend Sections 1612 and 1613, of the Mississippi Code of 1906, regarding the licenses of dentists, and fixing the time for holding examinations.

Be It Enacted by the Legislature of the State of Mississippi:

Section 1. That Sections 1612 and 1613 of the Mississippi Code of 1906, be amended so as to read as follows:

License Upon Examination. Every person who desires to practise dentistry in the State of Mississippi must apply, in writing, to the Board of Dental Examiners for a license to do so. Such application must be signed by two reputable citizens of the State, attesting that applicant is of good moral character and that he possesses an education equal to a high school graduation, and in addition thereto the applicant shall exhibit with such application a diploma or a certificate of graduation from some reputable dental college or school of dental surgery. The applicant must appear before the Board and be examined by it touching his learning and skill in dentistry, and if he be found to possess sufficient learning and skill therein, and to be of good moral character, the Board shall immediately issue to him a license to practise dentistry, which shall be signed by each member of the Board who attended the examination and approve the issuance of the license.

Sec. 2. *Examination—When, Where and How Conducted.* The Board of Dental Examiners shall meet at the capitol of the State on the third Tuesday in June of each year, for the purpose of examining applicants for license to practise dentistry; and to continue in session until all applicants for license have been examined and their examination has been approved or disapproved. All examinations, except as to character, shall be upon written questions on the following subjects: Operative dentistry, prosthetic dentistry, oral surgery, physiology, metallurgy, anesthetics, orthodontia; and in chemistry, anatomy, materia medica, pathology, therapeutics, histology and bacteriology, as they pertain to dentistry; together with a practical examination in

operative and mechanical dentistry, three members of the Board constituting a quorum for business.

Sec. 3. That this Act shall take effect and be in force from and after its passage.

House Bill No. 336

Amendment Approved March 25, 1922. An Act to amend Chapter 31 of the Mississippi Code of 1906, and Chapter 213 of the Laws of 1912, so as to prescribe a license and qualifications for the practice of Dental Hygiene in this State and to further regulate the practice of Dentistry and Dental Hygiene in this State and to provide a penalty for the violation of this act.

Oral Hygiene

Section 1. That all applicants for license to practise dentistry shall stand a satisfactory examination on the subject of oral hygiene in addition to and in the same manner as is required by law for the examinations on other subjects.

Dental Hygienists and Dental Hygiene Recognized

Section 2. That the profession of Dental Hygienists and the practice of Dental Hygiene are hereby recognized in this State and the State Board of Dental Examiners as heretofore established by law is hereby authorized, empowered and instructed to issue licenses for the practise of Dental Hygiene upon the conditions and requirements as hereinafter set forth in this Act.

Dental Hygienists Examinations

Section 3. Every person who desires to practise Dental Hygiene within the State of Mississippi shall make written application for examination to the Secretary of the Board of Dental Examiners, and must be over the age of twenty years, a graduate from some reputable dental dispensary, infirmary or school, and he or she shall submit, upon request, such proof as the Board may require as to age, character and qualifications. The applicant for license as dental hygienist, must appear before the Board at its regular annual meeting and undergo an examination touching his or her qualifications as a Dental Hygienist, and if said examination is satisfactory to the Board of Examiners, a license to practise shall be immediately issued to the applicant.

Limitation of Hygienists Practice

Section 4. That a license to practise Dental Hygiene shall only entitle the person in whose favor such license is issued to engage in the practice of removing lime deposits, accretions and stains from the exposed surfaces of the teeth or tissues of the mouth.

Supervision of Hygienists Practice

Section 5. That Dental Hygienists shall be entitled to practise their profession only when under the general direction or supervision of a regularly licensed and registered dentist of this State and while in the employ of such dentist or when in the employ or under the direction of the State Board of Health.

Fees for Examination

Section 6. Applicants for license to practise dentistry or dental hygiene in this State must each pay a fee of $25.00 to the Board of Examiners as a condition precedent to the examination, which fee shall be distributed among the members of the Board as their compensation in such proportion as the Board may allow. This fee is not returnable.

Recording License of Hygienist

Section 7. That every person who receives a license to practise Dental Hygiene shall file such license for record in the office of the Circuit Clerk of the County in which he or she shall reside, in the same manner and within the time as now provided by law for the filing and recording of licenses to practise dentistry.

Mississippi—Reciprocity

(House Bill No. 336—Amendment Approved March 25th, 1922)

Section 8. Any dentist or dental hygienist who desires to practise in this State and who has been practising his or her profession continuously for five years or more next preceding the date of his or her application under license lawfully issued by some other State or Territory, or the District of Columbia where the standard of proficiency equals that maintained in this State, may file with the Mississippi State Board of Dental Examiners his or her application for license to practise in this State without undergoing the examination for license, provided the application shall be accompanied with a fee of thirty-five dollars, which is not returnable, and the original or certified copy of the original license under which he or she has been practising, a certificate from the Board which issued said license setting forth the applicant's reputation for honesty, professional ethics, morality and professional ability, and such other information or data as the Board may deem expedient or necessary. Upon satisfactory proof of the applicant's fitness and ability being furnished, the Board may, in its discretion, issue a license to practise dentistry or dental hygiene to the applicant. But if the same courtesy or privilege is not authorized by law of the State, territory or the District of Columbia, in which said applicant has been practising, so as to permit registered qualified

dentists or dental hygienists of this State to be licensed therein, without examination, then the Board shall refuse to issue a license under this section, regardless of the applicant's fitness or qualification. But nothing in this Act shall prohibit such applicant from applying for the examinations for license.

MISSOURI, U. S. A.

The dental laws are dated 1888, 1897, 1905, 1917.

Board of Dental Examiners: V. R. McCue, President, St. Joseph; T. E. Purcell, Vice-President, Kansas City; Geo. E. Haigh, Secretary, Jefferson City; W. A. Roddy, St. Louis; C. W. Diggs, Columbia.

The English language, dental supervision, examination and registration are required. The Board of Dental Examiners meet in June at Jefferson City; examination fee $25.00.

Requirements and Instructions Governing Examinations

Applications for examination, accompanied by a fee of $25.00, credentials, including diploma, or a certified copy of their diploma, together with the college entrance requirements if the applicant has graduated within the past six years. (This does not apply to the members of the graduating classes of the colleges within the state, they being certified to by the college from which they graduate.)

Applications, together with the fee, must be in the hands of the Secretary of the Board at least ten days before beginning the examination. Applicants must also make affidavit as required on application blanks.

Applicants must furnish all instruments necessary, as well as material for all work. All must secure a license from the Board before beginning to practise. We do not issue temporary permits.

The board meets at Jefferson City the second Mondays in June and October for examining applicants.

Theoretical Examination

All examinations must be written in the English language, on the following subjects: Anatomy, Physiology, Oral Hygiene, Chemistry, Metallurgy, Histology, Bacteriology, Materia Medica and Therapeutics, Operative Dentistry, Prosthetic Dentistry, Oral Surgery, Orthodontia, Pathology and Crown and Bridge Work.

An average of 75 per cent is required in the Theoretical Examination.

Practical Examination

Prosthetic. Articulate and finish in wax a full upper and lower

denture. Make a banded Richmond crown for one of the superior anterior teeth.

Applicants shall provide themselves with upper and lower models mounted on an anatomical articulator, with the bite plates in position, and select a set of teeth suitable for case. The wax shall represent the finished rubber plates ready for introduction into the mouth.

The applicant shall have models of his own mouth (no difference how irregular) mounted on an articulator, with suitable facings and extracted teeth (roots to be prepared in the presence of the members of the Board) ready to make a Richmond crown for any one of the six superior anterior teeth selected by members of the Board.

Operative. Applicants will be required to prepare cavities and put in a gold filling and an amalgam filling. The "Black Method" is recognized as our standard and the same is required. Patients for the operative work will be furnished by the Board at Jefferson City.

Grading

Richmond crown. Preparation and adaptation of band to root, contact point and finished crown.

Artificial denture. Articulation, occlusion, arrangement of teeth, contour finished plate in wax and three point contact.

Fillings. Cavity preparation, finished fillings and contact points.

An average of 80 per cent is required in the practical examination.

Interchange of License

Missouri has an interchange of license with the following states: Iowa, Kentucky, Kansas, Nebraska, and Vermont.

Applicants desiring to take the examination under this clause shall comply with the above requirements.

Also a letter from the Secretary of the Board, in the State in which said applicant has been practising for the last five years just preceding, together with the seal of said Board, showing when applicant was registered in said State and that he has been in the legal and ethical practice of dentistry for five years or more.

It will also be beneficial to show that the applicant is a member in good standing of the State Association in which he has been practising.

Applicants under this clause are required to take the practical examination only.

For other details address George E. Haigh, Secretary, Jefferson City, Missouri.

Dental Laws of the State of Missouri

Laws of 1917. Sec. 5487. *Board to grant certificates to whom—examinations, etc.* From and after the passage of this Act it shall be

unlawful for any person to practise dentistry in the State of Missouri, or to attempt or to hold himself or herself out as a dentist until said person or persons shall first comply with the following requirements: Be examined and registered by said Board, and after receiving a certificate of registration the person receiving the same shall file such certificate of registration with the clerk of the county court of the county or counties in which he or she resides or desires to practise dentistry, and shall have the same recorded and a certificate showing the filing and recording of the same, with the book and page where recorded endorsed thereon under the hand of the clerk and the seal of said court; and thereafter any such person shall apply to and receive a license from said Board, which license shall attest the qualifications of the person named therein and shall give the person named therein the right to practise dentistry for the term mentioned in said license, which term in all cases shall end on the 30th day of November of each year, and shall be dated on the date such license is issued; and any such person shall, before attempting to practise dentistry or before holding himself or herself out as a practising dentist, have a name-plate prepared and placed in a conspicuous place upon the outer door of the office wherein the licensee practises or offers to practise dentistry, which name plate shall be in plain English letters giving the name of the licensee as it is written in said certificate of registration and license; the letters on said plate shall not be less than two (2) inches high. Any person attempting to practise dentistry, or holding himself or herself out to the public as a practising dentist before complying with each of the provisions herein named, shall be, upon conviction, adjudged guilty of a misdemeanor and punished as hereinafter provided. All applications for registration shall be made to said Board in writing, signed by the applicant upon blanks prepared and furnished by said Board, and among other things shall state his or her correct name, age, place of residence, color and nationality, the name of the school or schools attended by the applicant, the date of such attendance, and whether applicant is graduated from there, and if graduated, the name and address of the school and the date of graduation. Each applicant shall remit a fee of twenty-five dollars ($25.00) with his or her application. Each applicant must be at least twenty-one years of age, of good moral character and reputation, and must show that he or she is a graduate, and has a diploma from a reputable dental college, or the dental department of some reputable school or university which maintains a course of study equal to that required under this act, or shall show that the applicant has a license to practise dentistry from another State in force at the date of such examination; provided, such applicant has entrance credits or credentials for his entrance in such school or college equal to those required by this State at the time said applicant

entered his dental school or college, and such other information as the Board may require. Said Dental Board shall be authorized and empowered to appoint entrance examiners, whose duties it shall be to ascertain and determine by proper examination of credentials or certificates of preparation and qualification presented by such applicants, and where the applicant does not present such certificates of standing said entrance examiners shall be empowered to examine such applicants as to their literary qualifications required for entrance into any dental college or school in the State of Missouri. The method of examination for requirements for entrance shall from time to time be determined by said Board. Should any applicant for entrance misrepresent his actual credits to which he or she may be entitled, or shall receive any certificate which is a misstatement as to his or her actual literary qualifications, he or she shall upon conviction be adjudged guilty of a misdemeanor and punished as provided for in this Act; and any person who assists any applicant to misrepresent or fraudulently obtain any certificate or writing showing credits to which said applicant is not entitled shall likewise upon conviction thereof be adjudged guilty of a misdemeanor and punished according to the terms of this Act. All examinations for registration may be written, or clinical, or both, and of such character as to thoroughly test the qualifications of the applicant to practise dentistry or dental surgery. No person shall be eligible to registration as one competent to practise dentistry in this State unless the applicant in his or her examination shall make a grade or percentage required by the Board, which shall not be less than an average of seventy-five per cent in the subjects for examination required by this Act; it shall be the duty of said Dental Board to make careful investigations as to the moral standing of the applicant; the Board may in its discretion refuse to grant a certificate of registration to any person found guilty of making any false statement with intent to mislead said Board, or any member thereof, or who shall cheat, or attempt to cheat, or deceive said Dental Board or any member thereof, either in application for a certificate of registration, or in taking said examinations, or in procuring a license. If the applicant shall pass a satisfactory examination, and in the opinion of the Board shall possess the qualifications required by this Act to entitle him or her to registration as herein provided, then the Board shall issue to such applicant a certificate of registration, which certificate shall be signed by all members of said Board and attested by the seal of said Board; said certificate shall show that the applicant has passed all requirements of the Board and has been registered as a person who is competent to practise dentistry in this State; such certificate of registration, however, shall not authorize the person to whom it is granted to practise dentistry; it shall only be evidence of his qualifications to practise; before one may

practise he must procure from the Board, as provided in this Act, a license, authorizing him or her to practise dentistry.

MONACO

In the principality of Monaco, qualifications equal to the French diploma are required. Application, enclosing certified credentials, must be made to the Consul of the Principality, or to the Mayor of Monaco.

MONGOLIA

No dental license requirements are enforced according to the latest advices obtainable. Conditions are unsettled, and would not appeal to an alien dentist of the Occident. See China for other details, as Russia recognizes Mongolia as under the suzerainty of China.

DENTAL ECONOMICS

An Address to the Dental Students as the Dentists of the Future

By Hedley Ham, L.D.S., D.D.S., Melbourne, Australia

(Continued from September)

In seeking the value of our service, then, we should find the number of income hours, fix a standard average for each operation and find what the overhead charges or costs are and what they amount to.

First we determine the original outlay in investment on the dental education of the dentist and his expenditure for furnishing and equipping his rooms. You will probably be better able than I to assess these things. In all I should estimate well over $5,000. When the cost of your outlay is determined a sum is to be set aside to allow for depreciation and replacement if necessary. An inventory should be taken in detail, which may be used as a basis for calculating fire insurance. The value should be put down as if everything were new and written down each year. To allow for this depreciation of value of equipment, 10 per cent annually on the sum first invested in your outlay has been suggested as the lowest amount that can be put aside for this purpose. With this money replacements are made in furniture and equipment, as well as repairs. Any unexpended money for this purpose yearly goes into the cash account, but the ordinary supplies from the depot are kept separate from this fund for depreciation, which must be included in the overhead charges. Then we go a bit farther. Not only should the dentist prepare for the depreciation of his furnishings and equipment, but he should take steps to recover the whole of his investment in his dental education, and the way suggested to do that is to make a charge equal to 5 per cent of the whole investment annually and to take this amount out of the practice and invest it in an endowment insurance policy for accumulation, so that at the end of 20 years he will have fully recovered the whole amount, and if he should die the family recovers at once the amount invested. This amount is included in the overhead expense under refund. In the early years of practice this may be found hard to do, but it should be done as soon

as possible. These two items of expense, depreciation and refund, are then added to the other expenses, such as rent, light, power, telephone, laundry, attendant, assistant, stationery, books, insurance, dental materials, etc., with the exception of precious metals and teeth, which are added later on.

Now this yearly amount set aside for depreciation with the amount also for refunding the original investment, together with the other items of expense, will give the costs for the year, and if this sum be divided by the number of income hours, it will show how much it is necessary to expend to maintain the office during each income hour without providing for any remuneration, which is the sum left after all the expenses of the practice are paid.

It is necessary that provision be made for depreciation and the refund, or the remuneration will seem larger than it actually is. By this method all replacements are met by the depreciation fund, while the refund will more than pay for the investment in education and equipment.

The dentist knows also how much money he has for his personal affairs and does away with extravagance through ignorance of what he is earning, and he can determine how much his practice can pay him weekly as salary, which is his remuneration, as said before.

It is on these lines that fees are based. The lowest fee for any work to be profitable is estimated by adding the office expense per hour, plus remuneration, multiplied by the hours necessary for the work, plus teeth and precious metals, which are kept separate from the supplies account. Any reduction from this sum will reduce the manager's, that is the dentist's, remuneration, but not the other office expenses. The fees determined in this manner are equal only to the total office costs and need not be the fees habitual in the practice, but should not be less. The raising of the fees will give a greater remuneration, provided the community will stand the rise.

The cost of any dental operation may change from year to year by increased office expense, higher rents, improved methods of doing things, and particularly by the increased value of the dentist's time as he wins the approval of the community. The cost of an operation increases with the increase of his practice.

The cost need not be a maximum fee, but may be a minimum fee.

Each operation costs the dentist a certain amount. Each practice should be regarded as a business with the dentist as manager at a fixed salary, which is included in office expense.

In cases where no advance estimates are made he needs only to charge for the time involved, and the cost of any precious metals or teeth, but where an estimate is required he must know the average

length of time necessary for the operation multiplied by the income hour rate of his practice, and add the values of metals and teeth.

The fee, as said before, is the minimum charge and is obtained by the annual office expenses plus a reasonable annual salary as remuneration for the dentist, and this is divided by 1,000 income hours. The quotient is then multiplied by the hours or fractions thereof required for the average time of any operation.

Summary of Expenses

Depreciation (10% of the sum first invested).
Refunding investment (5% annually of the total investment, including dental college expenses).
Rent, heat, light, power.
Telephone.
Laundry.
Assistant.
Postage.
Taxes, insurance.
Magazines, books, stationery.
Miscellaneous.
Total overhead expense.
Dental materials and supplies.
Precious metals.
Total.
Annual expense (includes all above).
Annual gross receipts.
Less annual expense.
Amount available for remuneration and capital.
Subtract the amount for precious metals from the total sum of expense, add result to remuneration, and divide by 1,000 income hours. The quotient will be the minimum hourly fee. Add cost of teeth and precious metals to the final fee.

This system is a fair basis of computation as against fees made by usage or computation or per hour without knowing why. It also gives you the proper sliding scale, for a man with a small practice can take, say, one hour to do a filling at a certain fee; a man with double the practice can afford to spend only half that time on the same kind of work at the same fee, or he at once reduces his remuneration. Many a man keeps on working all his life at the same fees. The practice has increased in numbers, and what happens? Either he must work very much longer, or he must do the work quicker; and that means that a filling that should take half an hour is skimped and done in a

quarter of an hour. That is not fair to the patient or to the dentist. If the demand on his time is so increased, then he should advance the fee that will let him do the work properly in the properly allowed time for it, or he must send the patient to a younger practitioner who has the time and will be content with the original fee, or else the dentist must explain that for the fee that the patient is prepared to pay he can give him only so much time, and that instead of a contoured gold filling the work must be modified—he must put in an amalgam.

Take the point I made in the illustration of appreciation of values by patients. The starving man's life is saved by a simple meal, but the basis of the charge for that meal is the one made to all comers on the computation of the costs that the restaurateur has to pay to provide the meal. It is argued that the dentist should live up to his ideals and never do anything but the best work. That is true up to a certain point, but it would be absurd for a man to supply a gold plate and gold inlays at the price of a cement filling. If the patient can pay only for a certain grade, then that grade should be done in the very best way. There are restaurants where the poor man can get a very ample meal for a small coin, and there are restaurants with fine appointments, French chefs, etc., for which you are charged accordingly. There must be a standard of excellence in all work or the ultimate determination of fees becomes impracticable.

In closing this subject of fees, I should like to quote some lines from an article written by Kathleen Hills for one of the great American magazines *Leslie's Weekly,* and noted in Clapp's *Profitable Practice.* After many illustrations of bad dentistry, which affect the health of the community, she says, "First-class dentistry cannot be done cheaply. . . The low fees charged by the average dentist are positively inadequate to compensate him for the high class of service that should be given to every individual, for the tireless hours of work sometimes needed to execute the task. . . The average dental fee is a poor one. The solution of the problem is in paying by the hour. . . There is little danger of a conscientious dentist taking more time than necessary, so that the patient need not fear being overcharged. . . Economy in dentistry is not an interest-bearing investment." The trouble has been started in many instances by the methods employed by quack dentists. "It is against these members of the profession that the public is particularly warned. The first-class dentist will not have to advertise in emblazoned letters; his work will be the testimony of his ability. Often, when it is too late, the gullible person, who has been duped by the alluring statements of the quack,

finds out to his lasting regret how much less expensive in the long run is the work of the first-class dentist."

This article shows that the public is beginning to wake up, and it rests with you to do your duty.

(To be concluded)

Salesmanship in Dentistry

By W. E. Sargent, D.D.S., Gettysburg, S. D.

Salesmanship in dentistry is a valuable asset. If you are a good salesman you will get by, from a financial standpoint. There always have been, and always will be, arguments as to what constitutes a successful dentist. Is it the one who has restored the greatest number of teeth to their usefulness, thereby giving his patients comfort and greatly aiding digestion, etc.? Or is it the one who has made the greatest financial success? Of course, a combination of the two, you may say, goes hand in hand, but not always. I know dentists who work from early morn until late at night, and when the end of the year comes round they just have "paid out" and that is about all. I know others who spend from four to five hours a day in their office, have fine homes, cars, belong to clubs, etc., and always have the cash. You may say the latter get better fees. True—how do they get them?

Is it personality? Not always. I know men in our profession that get big fees although they have very little personality. They are salesmen. Not very good dentists, nevertheless they sell their services, purely because they have a way of impressing their patients that they know their business and are advising them for the best and go at their work with vim and snap, and at the same time are courteous and sympathetic.

I know a dentist—a poor workman—who has made a great financial success and who relies entirely upon his personality. He can quote the latest styles in dress, tell all about the latest shows, knows all the "stars," talks intelligently upon every subject except dentistry, wears flashy diamonds, has a fine personal appearance, and always attracts attention in a crowd, but when it comes to salesmanship at the chair, he is very weak. His personality gets the business—nothing else! I know another dentist who is a business man, always takes advantage of discounts, keeps his records in the best of shape, collects his accounts, and is a good dentist, but a poor salesman. He has made a financial success of dentistry simply because he knows values, both of time and expense, and has learned to invest his earnings wisely.

When you find a combination of salesmanship, personality, work-

manship and business ability in a dentist, you will find him truly successful. One of these traits is good, two better, three excellent, and four exceptional, when combined in one individual.

Some few years ago I had a patient who wore an upper partial vulcanite plate which he was always breaking and bringing in for repairs. He never brought the plate in without giving a long lecture upon the cost of maintenance. The last time he brought it in, I made up my mind that I was going to sell that patient a gold plate. I seated him in my chair and went after him; and before I was through talking he interrupted me by asking how much it would cost. I informed him $200.00, and if he didn't reach for his wallet and pay me $100.00 on the spot! He needed this plate, and since he got it he has sent me other patients. Before this he was always crabbing the "show."

One of the greatest drawbacks to the *poor* salesman is lack of nerve. Don't be afraid to step out after business! When you see that a patient needs a bridge or an appliance, or, in fact, if you see the least opportunity to improve his mastication, don't hang back—go after it!

The office girl has a great deal to do with successful salesmanship. When she receives the patient in the reception room, she should meet him in a cordial (not overfriendly), pleasant way, which will give the patient an impression of interest, and should always look to his comfort and wishes. When the dentist is ready to receive the patient, the office girl should always seat the patient, make out the card—or if an old patient, get out the old card—placing it on the cabinet for reference, adjust the chair and place the towel, being pleasant at all times.

Right here is where the make or break comes. It is the first introduction of the patient into the dentist's presence which either gets or loses the confidence of the patient. Cleanliness, arrangements, equipment, personal appearance of office assistant and dentist, all have an influence on the patient. If the assistant has made the appointment, received and seated the patient, it creates a good impression on the patient to have her introduce the patient to the dentist. The dentist should show an interest in the patient more than just "looking down in the mouth."

When the examination is completed, the time for the actual salesmanship commences. State frankly, and as briefly as possible, the defects found, methods of repair or replacement, possible results to be expected (if you are allowed to pursue your intentions) to put the patient's organs of mastication in first-class condition, amount of time the patient will be expected to spend in the chair, and, lastly, the cost and the method of payment expected (if you are doubtful of patient's financial condition). Above all else, try to get the confidence of the patient; be kind, careful, courteous, and very businesslike. Give the patient the understanding that the price is of least importance, that

the restoration of his teeth is the only consideration. Of course, one can't overlook the necessity of pay for the work. Have a thorough understanding before the work is started; then there is never any chance for an argument afterward, and you'll have very little use for a bill collector.

Price competition cuts very little figure with the patient, provided you have properly led him up to the point. Never start your patient on price—always paint your picture before you try to sell it! Don't try to impress a patient with the fact that you know it all. Try to get him to realize the importance of the service without having to tell him what will happen if he doesn't follow your advice. I know of a dentist that insists upon telling his patients that if they "don't have that tooth filled they will soon have an awful toothache, and the tooth will probably abscess and cause rheumatism, arthritis, or heart trouble, and that some instances have been known where people have even lost their lives in the conflict." When he sees a patient needing a bridge he tells him he "will have stomach trouble, constipation of the bowels and is spending too much money for food out of which he gets no good." He paints his picture so black that the average patient gets scared or loses confidence entirely.

Often it is hard to paint the picture vivid enough so that the patient can see it. I know a dentist whose assistant has nearly every kind of dental work in her mouth, and the dentist uses her to show up the finished work. This is a very good plan, since people as a rule like to see what they are buying; it is the patient's right. You wouldn't buy a suit of clothes without first examining the goods, and you rather like to pick out the style the suit is to be cut after, too. In other words, you want to have something to say about that suit of clothes. People are all alike. Some dentists take the stand that the general public doesn't know anything about teeth. Maybe they don't, but most of them have a pretty good idea of what they want! I do not mean that the dentist should ask the patient how he wants the tooth filled, bridge constructed or crown made, but a patient does like to have you take him into your confidence and "talk things over," and if you have obtained the confidence of the patient you will have very little trouble in doing just as you wish.

Never let money get into your eye in advising your patients. Be conscientious in your advice, and it will reap a harvest far in excess of the small fee you may receive by misleading your patient. Someone has said: "A physician and a surgeon bury their mistakes, but a dentist's mistakes act as boomerangs."

Never let the fellow across the street or across the hall have the least influence on you. He may do cheaper work than you; you may not be planning on doing the same grade of work that he would do if

he had the case. There was a case in Pasadena, California, a few years ago, which is a good example of this, of two dentists practising across the hall from each other. Dr. A. was considered a high-priced dentist; Dr. B. was getting about one-half the fees. One day Dr. A. set a four-tooth bridge for a patient and charged the patient $1,500 for the work. It happened that this particular patient, so the story goes, thought that was too cheap. He went across the hall to Dr. B. and insisted on Dr. B. making him a good bridge. Since Dr. A. and Dr. B. were good friends, Dr. B. tried to persuade him that this was a fine piece of work, but he insisted that Dr. B. remove the bridge and make him a "good one," which Dr. B. finally did, charging the patient $3,000 for a bridge not any better than the one Dr. A. had made. However, the patient was satisfied that this one was better than the first because it cost more money!

Don't be afraid to ask what your services are worth. The "Keen Kutter" toolmakers use the slogan: "Quality remains long after price is forgotten," and that applies very well to dentistry also.

I wish to place stress upon the importance of cleanliness, proper arrangement of office equipment, courtesy, a certain amount of self-reserve, sincerity, personality and workmanship in salesmanship. The more of these you can combine in one office the better results you'll obtain, from a financial standpoint as well as from the standpoint of a successful practice.

PRACTICAL HINTS

This department is in charge of V. C. Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 610 California Building, Denver, Colorado. To avoid unnecessary delay, Hints, Questions and Answers should be sent direct to them.

NOTE—Mention of proprietary articles by name in the text pages of the DENTAL DIGEST is contrary to the policy of the magazine. Contributions containing names of proprietary articles will be altered in accordance with this rule. This Department is conducted for readers of the DENTAL DIGEST, and the Editor has no time to answer communications "not for publication." Please enclose stamp if you desire a reply by letter.

TO STERILIZE IMPRESSION COMPOUND IN ELECTRIC STERILIZER: Enclose compound in napkin and boil. Dip in cold water and compound peels off nicely.

R. O. BRITTAIN.

Editor Practical Hints:

A good way to remove teeth from vulcanite plates is as follows, if you wish to save the teeth:

Put the plate on a thin sheet of iron, holding it over a gas flame, and let it heat up so you can push the teeth off. If you find small sections of rubber around the pins put in chloroform over night and you can push it off like magic. Some dentists do as you stated and use no oil (Dental Digest, page 376), but this is taking a chance of checking the teeth.

E. C. L.

Editor Practical Hints:

I have a case of an upper denture that (as the patient describes it) burns the roof of the mouth and the tongue after being worn about half an hour; she then removes it and does not wear it much except when she goes out in company.

Patient had plate made seven years ago by another Dentist and has had this trouble ever since.

She came to me about a year and a half ago and I refitted and relined her plate with dark elastic rubber to no effect; I then relieved pressure over blood and nerve centres to no effect; I then relined plate

again with gold lining material, and it then took about half an hour longer before burning began.

Last time I removed Palatine portion of plate, making a horseshoe plate out of it, and she is now trying it out that way. Patient lives in country and does not get in very often.

I was considering making a gold plate with tube teeth, but would like to have your advice in the matter before going further.

There seems to be no soreness or inflammation whatever in the mouth; just that burning sensation as the patient describes it in roof of mouth and in tongue after plate is worn awhile.

Patient is wearing partial lower plate but does not complain so much about that, but thinks something should be done with it too.

Any advice from you in the matter will be very thankfully received.

W. A. S.

Answer.—Replying to your letter, I am going to publish your inquiry with a plea to our readers for help. If anyone can describe a sure and easy solution of this difficulty it will certainly be greatly appreciated by myself as well as by you and, I have no doubt, a great many others of our readers.

I have two such cases on my hands right now, and I must say that they are about as trying and difficult to secure a comfortable and satisfactory result as any type of case that comes to my office. Usually these patients can be made comfortable by construction of a denture that relieves the foramena areas from all pressure.

Gold is certainly preferable to rubber in all of these sensitive mouth cases, assuming an equally accurate fit with each material, but gold will not necessarily always relieve this burning sensation although it usually will do so. I have had more universally satisfactory results with the platinum and baked porcelain (continuous gum) dentures, but these two cases I am having difficulty with now are either unable or unwilling to invest in continuous gum dentures. The gold plate with tube teeth as you suggest might accomplish the desired relief for your patient. I would think, at any rate, it is well worth the effort but, as stated above, I do hope that some of our readers will be able to furnish both of us with information as to how to make these people comfortable as simply and inexpensively as possible.—V. C. Smedley.

Editor Practical Hints:

One of my patients, a little girl fourteen years old, presented some time ago with badly swollen and bleeding gums. This condition was confined to the gum tips and was more or less general over whole mouth. There was little scale in the mouth, and after treating and

prescribing home treatment, which I am sure has been carried out, I have improved the condition only in part. The upper anteriors still persist in bleeding and also some of the posteriors. The contact points are minus between teeth giving most trouble, and this is only source of irritation I can find.

Have exhausted every treatment known to me, and would appreciate some suggestion.

L. V. H.

ANSWER.—Your case is one of many in the adolescent period. The tissues seem more susceptible to the effects of irritation and less responsive to treatment in certain individuals during the teen years. I have never been able to correlate this tendency to chronic hypertrophy with any definite systemic condition, except that it is usually with low resistance and anaemia. Therefore it would be advisable in your case to investigate the systemic condition and have whatever treatment instituted that the conditions may indicate.

The matter of malocclusion should also be considered, as in malocclusion we are more apt to have chronic inflammatory conditions of the periodontium. Furthermore, don't relax your vigilance in regard to the prophylaxis and home care. Give a prophylaxis treatment once a month and by means of disclosing stain ascertain if home care is as efficient as it should be. The formula for disclosing stain is:

Iodine Crys.	gr. 50
Potass. Iodide	gr. 15
Zinc Iodide	drams 4
Az. Destill	drams 4
M. et. Sig.	Staining Solution

G. R. WARNER.

Editor Practical Hints:

I have a patient who has continual trouble with overflow of saliva. He has about eight amalgam fillings and one four-tooth bridge. He is a city fireman; his digestion and general health are good. He is an habitual tobacco chewer. He stopped chewing for one month but this did not help.

At night he must use a towel under his head so as not to soil linen.

Kindly help me with this problem and suggest a remedy.

A. K.

ANSWER.—There is not a great deal in the literature in regard to ptyalism. As far as is known it is caused in men by drugs such as iodine and mercury, by tobacco chewing, in nervous disorders and by mental diseases.

In the case of tobacco chewing I should think that stopping for one month would not be long enough to demonstrate that the tobacco chewing was or was not the cause.

The treatment for this condition is small doses of the bromides or the atropine.

I do not believe that the amalgam fillings in the same mouth with the bridge would be a cause of ptyalism.—G. R. WARNER.

Editor Practical Hints:

Was recently asked by a medical man what liquid or solution was the most powerful in penetrating dentine. Was forced to confess my ignorance in regard to this.

It has occurred to me that undoubtedly research work has been done along this line. Do you know of such experiments carried on, and if a general report was made? Can you name me ten or more of the most powerful drugs in this respect?

I will greatly appreciate any information you may have.

C. E. H.

ANSWER.—Would say that hydrochloric acid in an approximate 50 per cent solution is the most efficient in breaking down dentine. This is the method commonly known as the Callahan method, and is the result of many years' experimenting on the part of Dr. Callahan. The Dental Index will furnish you with all of the articles written by Dr. Callahan upon this subject.

I assume that this is the thing you wish to know although you say, "what liquid or solution is the most powerful in penetrating dentine." Do you mean a liquid or solution which can be forced into dentine, or do you mean one which will penetrate or permeate without force, or do you mean one which will dissolve dentine? My answer is in supposition that the latter is what you desire. All of the powerful acids such as sulphuric, nitric, and hydrofluoric have this effect.—G. R. WARNER.

Editor Practical Hints:

I get lots of help from the Practical Hints in THE DENTAL DIGEST, and wish to get your opinion on the following case:

My son, age 9, had both his permanent centrals knocked out in an automobile accident. The laterals are just beginning to come through the gums, and all the other teeth (temporary and permanent) are in place and without decay. It is an upper case.

Can you tell me the kind of appliance I should use to hold the laterals in place, so that later I can put in a bridge. Do you think a

small partial plate, with the two centrals on it, would be best?

Any help you can give would be greatly appreciated.

J. E. H.

ANSWER.—I believe that the most satisfactory temporary restoration in such a case is a temporary bridge made by soldering the two central incisors to narrow orthodontia bands fitted to and cemented in place upon the laterals. This, of course, should not be done until the laterals have fully erupted, until which time the proper space may be maintained between the laterals for the centrals by placing a small orthodontia arch attached with bands to temporary molar on each side, with a little spur just touching lightly the mesial surface of each lateral.

This temporary bridge may and should be removed from time to time, as orthodontia bands and appliances are for the sake of polishing and keeping the teeth clean for prevention of decay.

—V. C. SMEDLEY.

Editor Practical Hints:

Have read several articles printed in your Dental Digest on Trench Mouth, and wonder if you could give me any information on the origin of this disease, and if possible any known formula for the cure of same.

MISS M. DU M.

ANSWER.—I know of no formula or treatment that patients should attempt to administer to themselves at home without the advice or prescription of a dentist.

Would refer you to answer by Dr. Warner on page 628 of the August DENTAL DIGEST for further information covering Trench Mouth treatment.—V. C. SMEDLEY.

Editor Practical Hints:

I have three cases which I would like to have your advice upon. The fact that they are all practically the same makes me think that it is some fault of technic upon my part.

They are all upper plate cases and I find that regardless of what I can do they will in time break through the median line. A very small crack develops which gradually grows larger until there is a crack clear through the plate in the region of the central incisors and parallel with the median line. I have repaired these cases with several gold wires in the palate just posterior to the ridge, where the stress is the greatest, and I find them back again in a month or more with the same condition as before.

The teeth are set up as near to the center of the ridge as possible,

but as the cases are all set up to natural lowers this is rather difficult to attain. The palate in these cases is rather hard, with a thin membrane, while the ridges have a membrane of normal thickness.

Your advice on this matter would be greatly appreciated.

L. E. W.

ANSWER.—The cracking of these plates is a perfectly logical result in these mouths with the conditions as you describe them. With the teeth occluding against rigid, unyielding natural teeth on the lower jaw and with the upper supporting area softer over the ridges than over the median line you naturally get a severe leverage upon the unyielding portion of the palate in the center.

In most cases where these conditions prevail the breaking can be avoided by the manner of taking and preparing the impression which should be done in such a way as to relieve the harder area in the center from any undue pressure from the plate under stress of mastication. This can be provided with the modeling compound technique as is described in Professional Denture Service, by Dr. G. W. Clapp, or with the plaster technique by scraping the impression judiciously over the harder area before pouring cast.—V. C. SMEDLEY.

Editor Practical Hints:

Have a patient, male, 38 years old, who is troubled with a severe pain on left side of face extending from temporal region to the lower portion of mandible. This area is so sensitive to the touch that he is unable to shave or wash his face without causing excruciating pain. Have x-rayed his teeth, also taken lateral jaw and found nothing. Has some bridge work above, abutment teeth being vital.

Please advise technic of the alcohol treatment, points of injection and anything you may think will help me out on this case of tic douloureux, as I have diagnosed the trouble.

R. J. S.

ANSWER.—In looking for a cause of trifacial neuralgia don't overlook pulp stones. A number of cases of this sort have been reported. It is also possible that you have caries under the abutments of the bridge causing irritation of the vital pulps. Periodontoclasia and impactions are also prolific of neuralgias. Then there are systemic causes, such as hypertrophy or atrophy of nerve trunks, disease of the paranasal sinuses, poisoning, lues, or any disease which might markedly lower the vitality.

I speak of these things because the treatment of trifacial neuralgia by alcoholic injection is fraught with so much danger that it should

be used only as a last resort, and then only in the hands of one experienced in making the injection. Moreover, the relief from alcoholic injections is only temporary in most cases. The technic of an alcoholic injection is much too complicated and extended to be given in this department, and as indicated above is inadvisable for a dentist to undertake.—G. R. WARNER.

Editor Practical Hints:

Will some kind reader of DENTAL DIGEST assist me in diagnosing the following mouth condition: Patient develops inflammation of tongue, lower lip and mucous membrane of entire mouth; feels like entire mouth was scalded; inflamed and fiery red; there is a smarting of tongue, and tongue also burns like fire after eating. This condition only takes place during course of dental treatment, whether it's a small amount of work or an extensive amount.

Patient is not bothered with that condition at any other time. Have used all kinds of mouth washes, but of no avail.

G. P. G.

ANSWER.—I have no knowledge nor have I been able to locate any information covering this case, but will be glad to publish your question and, no doubt, some of our readers will be able to enlighten us. —V. C. SMEDLEY.

CORRESPONDENCE

Admission to the Dallas Meeting

(EDITOR'S NOTE—The following communication was forwarded to the Editor with a request that it be printed in THE DIGEST as a reminder regarding an important amendment concerning applications for membership during the annual session of the A. D. A.)

September 5, 1924.

Dear Doctor:

The House of Delegates at the 1923 meeting at Cleveland passed by unanimous vote an amendment which now makes it impossible for the General Secretary to accept applications for membership at the annual sessions. Therefore, no dentist living in the United States will be permitted to attend the meeting in Dallas unless he is an active member or presents satisfactory credentials from his state society.

I trust that you will magnify this new law of our Association so that no dentist from your state who is not a member of your society will go to Dallas with the expectation of securing admission to the meeting.

Active members should bring their membership cards, thus avoiding misunderstanding and delay at the registration window.

Looking forward to the pleasure of meeting you at the great Dallas meeting, with best wishes, I am

Fraternally yours,

OTTO U. KING,
Secretary.

Editor, DENTAL DIGEST:

The following statements are strictly correct and true, and are about an experience in the practice of a young man of 24 years in the year 1875.

A lady (name and history now unknown to me) came with a supersensitive central with pain so unbearable that further work was abandoned. The central and its root and gum connections were perfect except the approximal corner.

The tooth was extracted, placed between two old pieces of heavy

leaf lead and opened up, the nerve removed, and cavity filled to the end of root. The corner was restored with gold and polished, the tooth taken from the lead, cleansed, and was ready for replacement. The socket was washed, cleansed and swabbed with carbolic acid, after which the tooth was restored to its socket and pressed home.

The lady came back the next and on subsequent days. The wonder then, and even now, is that there was a *perfect union—no soreness.* Germ theories were not known in those days, and I violated every method so much lauded today. Is the germ theory only a passing fad?

REUBEN W. MORRIS, D.D.S.

902 Haas Building.

Editor, DENTAL DIGEST:

A boy two years old has set a good example for other children to visit the dentist early. He had one of his molars filled when the cavity was small. Who can name a younger dental patient on record?

C. H. R.

DENTAL LABORATORIES

How Dr. Monson's Spherical Principle Can be Applied to Dental Laboratory Service*

By B. I. Martinez, St. Paul, Minn.

When I was offered this subject by your committee, I realized the fact that it is one to which at the present time the laboratories have given very little consideration, partly due to the demand by the dental profession, but I believe the time is here when we should prepare ourselves to render to the profession a service above the old straight-line articulation and adopt principles which will increase the efficiency of dentures by a balanced occlusion. On this basis I present a method referring only to edentulous cases. Partial dentures and reconstruction cases might be included in the service to be rendered, but, owing to the amount of preparatory work necessary to be done by the operator, he himself must also be well versed in the Spherical Principle. Therefore I believe that in the latter two classes of work very little cooperation can be had with the laboratory outside of the finishing of the cases.

I am not going into the merits of the Spherical Principle, but, taking for granted that you all know its fundamentals, I shall endeavor to place before you the method which I employ to cooperate with the dentists who desire a case made on the Monson Instrument.

Aside from the merits of the Spherical Principle, I am convinced that the success I have experienced is due to the close cooperation necessary between the dentists and the laboratory. St. Paul being the home of Dr. George Monson, naturally the dental profession was enthusiastic over the principle as advocated by him. Clinics were given to the members of the District Society, and study clubs were formed; but while all professed admiration and enthusiasm, a small percentage actually were keeping up the work. Why? My reasons are these. The Monson or Spherical Principle, as taught by the clinician, did not provide for cooperation with the laboratory, and I found that there was a feeling among a number of the dentists that they would use the

* Read before the American Dental Laboratories Association at Cleveland, September 12, 1923.

Spherical Principle provided a certain amount of work could be done by the laboratory. I found also that a number of dentists, while enthusiastic, would not or could not afford to invest in a Monson Instrument. From this I conceived the idea that what was needed was cooperation and the placing of these instruments at the disposal of the dental profession.

The problem was solved to a certain extent by offering the use of a Monson Instrument to dentists and employing a standardized method as follows. The operator takes the impression. It is optional on his part whether he makes the models or sends the impression to the laboratory to have it poured, but I insist on the model being returned to have the baseplates and occlusal rim adapted. These are made from Monson's or Graft's baseplates and a hard wax for the occlusal rims. The reason for using the above-mentioned baseplate is on account of its properties, as it is not changed by mouth temperature and is rigid enough to withstand ten to twelve pounds of pressure when seating the trial dentures.

The baseplates must be accurately adapted to the casts so that there will be no shifting of the trial denture in the mouth. The success of the finished denture depends upon accurately obtaining and maintaining the correct relation of the mandible to the maxilla. This relationship is established and transferred to the instrument by means of the trial denture. It is, therefore, very important that the baseplates accurately fit to prevent any false relationships in the transfer, the setting up of the teeth, or the try-in.

Test for fulcrumage and atmospheric pressure.

Preparation for Baseplates to Establish Normal Facial Dimension in Central Occlusion

1. Build occlusal rims to 9 mm. in height, which is Dr. Black's average measurement of the crowns of the anterior teeth plus any absorption which may have taken place.

2. The occluding surfaces of the rims should be trimmed to conform to the surface of a sphere having a diameter of approximately eight inches.

3. This is the only form of occlusal rim which equally distributes the applied force in securing the relation of the mandible to the maxilla and maintains the perfect adaptation of the trial denture to the mouth.

The casts and baseplates with the occlusal rims are returned to the dentist.

The normal facial dimension and relation of condyle are established by the dentist. From this point we again take charge of the case,

using the transfer bow for the transfer of the baseplates to the instrument in the same relation as determined by the operator.

1. Transfer plate; transfer bow.

2. Establish relation of the condyle by putting a mark on the center of the tragus of the ear; then put another mark one-half inch forward of the tragus of the patient's ear; attach the transfer bow tightly to the upper occlusal rim; replace the trial plates in the mouth, having previously placed a piece of softened beeswax of the size of a hazelnut in the region of the bicuspids and first molars and have the patient close, obtaining the most retrusive position of the mandible. Adjust the ends of the face bow so that they intersect the mark one-half inch forward of the tragus of the ear, as marked on the patient's ear. Now remove the upper and lower trial plates with transfer bow attached. Have the friction and control screws locked on the instrument. Have the screw on the radial arm locked in the most forward position. Insert the condyle rod on the instrument. These rods represent a line drawn through the center of the condyles of the patient, extending laterally.

3. Set the dividers at four inches.

4. Have the incisal edge of the lower occlusal rim four inches from the top of the instrument. The posterior part of the case is taken care of by having the ends of the transfer bow intersect the condyle rods at an equal distance from the ends of the rod.

5. Secure the lower cast to the instrument.

6. Secure the upper cast to the instrument.

7. Remove the transfer bow and transfer plate, closing the case to the relation established in the mouth, and then mark the median line on the upper and lower casts. Make a mark across this line on both casts with the dividers; then record this dimension on the side of the lower cast for a permanent record.

We are now ready for the setting up of the teeth. I insist on being present for the try-in to observe.

Three Things to Observe at Try-in

1. Whether we have central occlusion, which means when the teeth are in occlusion and the mandible is in its most retrusive position.

2. If we have not secured central occlusion, this can be corrected by having the patient bite in check-bite wax which is softened enough to get a good impression of the occlusal surface of the teeth but not soft enough to get cusp interference. Place the lower trial denture on the cast and place the check-bite wax on the occlusal surface of the lower denture. Now loosen all control screws on the instrument, then place upper trial denture on the upper cast. Place the occluding

surface in its respective impression on the check-bite wax. Next lock the instrument by tightening the friction screw and the screw on the radial arm; then reset the upper teeth to corrected relations. (Do not use the centering screw, as this would throw it back to its former registration.)

3. During conversation with the patient note whether the labial surfaces of the lower teeth advance to correspond with the labial surfaces of the upper teeth. If so, the overjet is sufficient. If the labial surfaces of the lower teeth advance beyond the labial surfaces of the upper teeth, the overjet is insufficient. To correct this, carry the upper anterior teeth forward or the lower anterior teeth backward, or both, as indicated by the type in esthetics.

4. If for esthetic reasons the upper teeth show too much and the lowers not enough, the teeth must be reset to a shorter radius which will lengthen the lower teeth and shorten the uppers without changing the dimension established with the occlusal rim.

After I am satisfied that the bite is correct, I let the operator stagger the anterior teeth as he desires, for I believe that esthetics is governed by the individual ideas of the operator.

The case is now completed in the laboratory by the use of Dr. House's technic for finishing dentures.

Do not misunderstand me when I say that cooperation alone has proved successful, for it must be combined with a knowledge of the Spherical Principle on the part of the technician.

I should advise the technician who is interested in this method to prepare himself to assist dentists by joining or forming a study club and keeping himself well informed on this principle.

308 Lowry Building.

DENTAL SECRETARIES and ASSISTANTS

Meetings to be Resumed

The Educational and Efficiency Society for Dental Assistants, First District, New York, Inc., will resume activities for the season 1924-1925 on October 14th, at 8 P. M. The meetings are to be held at the Academy of Medicine, 17 West 43rd St., New York City. The Program Committee announces speakers of interest.

Classes in Public Speaking, Roentgenology, Laboratory Technic, Sterilization, Office Regeneration and other phases of dental assisting will be continued as in the past.

The Clinic Club meets September 22nd, and the third Monday of each successive month. The sections demonstrating what an efficient dental assistant can do for better service to the dentist and patient comprise: Secretarial, Chair Assistance, Sterilizing, Orthodontic Assistance, X-ray and Laboratory Assistance.

Meetings are held on the second Tuesday of every month from October to May, inclusive. Interesting programs are prepared, and a cordial invitation is extended to all dental assistants to attend the meetings. Members of the dental profession are also cordially invited.

BERTHA S. UNGRICHT,
59 East 54th Street, New York City,
Chairman of Publication Committee.

American Dental Assistants' Association

Organization Committee.

To Dental Assistants' Societies:

A National association for dental assistants is to be organized at Dallas during the meeting of the American Dental Association, November 10th-14th, 1924.

It is proposed to follow as closely as possible the plan and ideal of the American Dental Association.

For the purpose of organization we urge that every society for

dental assistants send a properly accredited representative to Dallas. In the event of your society not being able to send a delegate will you not join in the organization by sending to the Organizing Committee necessary credentials to act for you.

These credentials should be authorized by motion or resolution adopted by each society and should include a copy of the motion or resolution attested by the President and Secretary.

We earnestly solicit your active co-operation in helping to make this movement a success and will appreciate a prompt reply.

Cordially yours,

JULIETTE A. SOUTHARD, Chm.,
174 West 96th Street,
New York City, N. Y.
JESSIE C. ELLSWORTH, Chicago, Ill.
MERLE COTTER, Des Moines, Iowa.
IDA L. DIXON, Peoria, Ill.
ANNA SYKORA, New York City, N. Y.

A New Society

The Baltimore (Md.) Educational and Efficiency Society for Dental Assistants came into existence on September 3rd at an organization meeting at which Miss Katherine F. Morris was elected temporary chairman and Miss Dorothy Hood secretary and a committee on by-laws and constitution was appointed.

The next meeting of this Society will be held on October 8th at the Baltimore College of Dental Surgery.

EXTRACTIONS

No Literature can have a long continuance if not diversified with humor—ADDISON

(A Railroad Crossing Sign)—Stop! The locomotive doesn't know you're crazy!

Imaginary ills have their uses. They keep doctors out of the poorhouse.

The Prince of Wales must like England pretty well. He goes back there every little while to stay several weeks.

"Fare, please," shouted the bus conductor on one of the busy streets of Boston. But the passenger addressed paid no attention to the demand.

"Fare, please," he again repeated, but the passenger remained oblivious.

"By the ejaculatory term Fare!" said the conductor, "I imply no reference to the state of the weather, nor even to the quality of the service vouchsafed by this philanthropic company. I merely allude, in a manner perhaps lacking in delicacy, but not in conciseness, to the monetary obligation incurred by your presence in this bus, and suggest that you liquidate."

"Oh! all right conductor, here's your nickel!"

(Astrologer)—"Mr. Editor, I have here a very fine article on 'The End of the World. Jan. 1'."

(Editor)—"Yes, let me have that. It ought to be very interesting."

(Astrologer)—"And the fee?"

(Editor)—"You get $500 on Jan. 2 if your prediction comes true; otherwise you don't get a damned cent."

(Rube)—I'm tired of this inactive life. I want toil, danger, excitement and adventure.

(Sally)—This is so sudden! But you may ask father.

A chorus girl was discharged from a New York musical show because of her notoriety. Now shine your shoes for the millenium!

(Harry)—Do you always let your wife have her own way?

(Egbert)—Absolutely. And when it wants to rain I let it rain. And when it wants to snow I let it snow.

Some people think they have open minds simply because they have their hats off.

An automobile party stopped at a wayside restaurant for lunch. After looking over the bill of fare a member of the party asked the proprietor if he gave any reduction in prices to those in the same line of business?

"Yes," he replied; "do you run a hotel?"

"No, I'm a burglar."

One way to get acquainted with a lot of prominent people is to get on the jury.

(Doctor)—You cough more easily this morning, young man.

(Patient)—Yes, Doc, but I've been practising all night.

We know an old duffer who is so absent-minded that the other night when he heard himself knocking the ashes off his pipe he called out, "Come in!"

(First Dentist)—What do you think of my new offices? You see, the fire escape here makes my waiting room one of the safest places in the building.

(Second Dentist)—Safe nothing! I lost twelve patients that way.

One way to keep a daughter at home is to feed her on onions.

A recent meeting of the League of Nations ran true to form, according to authentic reports. It was opened at 10:00 a. m. with a prayer for peace or what have you, and promptly at 10:37 China began a new war. Reports on naval disarmaments were brought up for consideration at this same meeting, and it was shown that Mexico, Switzerland and the Republic of Zion are living up to the required basis of naval strength. Information from the United States disclosed that we have junked one Fall River liner, two New York Central ferryboats and quite a few of the Ford destroyers.

DIETETICS and HEALTH

On Going on a Diet

By Walter S. Keyes, D.D.S., San Diego, Cal.

When you have the contents of your stomach analyzed—which is preliminary to going on a diet—you first eat some last year's toast, after which you are persuaded to swallow some three feet of rubber hose that has previously been lubricated with vaseline to make it palatable. The nurse asks you if there is anything you would like to read while the toast is being attacked by your digestive fluids. You reply in the affirmative, naming several books that you would like to read, but being in a doctor's office, none is available, so you say that you do not care to read, and fall to observing a sparrow making love to another sparrow on the window ledge. The male bird you think is doing a fair job of love-making, but the female seems more or less uninterested, a little wary like the woman who has been married two or three times for her money. By and by the birds fly away to a more remote and romantic locality.

"Nurse," you gurgle, "did you ever swallow any hose, that is, rubber hose?"

"No," she replies, "but I have read Carl Sandburg's poetry, which I believe is equally bad." Then she takes hold of the hose and begins to pull gently, hand over hand like a man climbing a rope, and finally the submerged end, much to your relief, flips out of your esophagus. All of this—except the sparrow incident—varied slightly in technic, is preliminary to going on a diet.

When you go on a diet you can simplify matters very much by voluntarily eliminating from your menu the things you have always liked to eat, substituting for them the things you have always detested. This may seem a little unjust to you, but it is not. If you have been active in stimulating the market conditions for such foods as mince pie, candy, sugar, fruit and lobster à la Newburg, you certainly owe a duty, as an unprejudiced citizen, to the dairyman, the spinach grower and the manufacturers of Dreaded Wheat Biscuit, Rolland Husks and Zwieback.

One of the real pleasures of going on a diet is telling about it. You always feel at liberty to say to friend or stranger that you are

on a diet; stating, if you want to go into intimate details, that you have consumed so much milk and cream and sweet butter, that your transmission is running in oil and that your other internals are being adequately lubricated by a splash system. You will be surprised to find that nearly every one you meet has been, or is now, dieting because of a pain or pang, or to gain or to reduce—the reducers no doubt predominating—especially among your women friends. Quite often you will also find a person who has had a friend who passed away on a diet, and if there is envy in your heart and a gripping pain in your stomach you will envy the last-mentioned first and most. It will also be a source of wonderment to you to find that so many people converse easily and carelessly on such subjects as proteins, carbohydrates, fats, gastric secretions, vitamines and calories.

Your being on a diet will be a great incentive to your friends to invite you out to lunch and to dinner. This unromantic occupation of dieting would get the most remote and secluded hermit into a dinner suit in a shorter space of time than it takes the average woman candidate to enumerate the reasons why she is particularly fitted to serve on the local board of education.

When you are invited out to dinner you are invariably served oyster cocktail, fried chicken, mince pie, warm biscuits and perhaps a forbidden salad or two. In fact, the table will be groaning audibly with its load of good things to eat while you groan inwardly and silently with an unsatisfied longing. Finding yourself seated at the table of a friend, you first cough behind your napkin. The cough is to arrest attention, because a person on a diet, except for a certain wistfulness of demeanor, carries no other distinguishing marks or manifestations of what really ails him, so he must do something to attract the attention of those about him. By this time you cough again, and before you can explain to your hostess your predicament you are served a brimming plate full of the things you used to eat and still like. At this point your wife comes to your rescue by saying, "You know, Mrs. Jiggs, Doctor is on a diet, for the benefit of his stomach and—and we hope his disposition as well!" At this point you kick her on the ankle quite severely, and she, kicking back, signifies through an unwritten code that she is through and cuts you adrift. So you take the oars yourself and say, "Yes, I'm on a diet, but I can't possibly refuse such a splendid meal as this. I'll forego dieting just this one time," and you smile at your hostess. In justification you say to yourself, "Think of asking for Dreaded Wheat Biscuit and cream in hot water at a spread like this!" Immediately, beneath the shelter of your napkin, you let out your belt a couple of holes and fall to.

Your hostess says, "Doctor, don't you honestly think that the cooking of food largely determines its digestibility?"

With your wife so close at hand you feel that this will be a difficult question to answer, but, fortunately, a lady across the table upsets a glass of water which diverts your hostess to other concerns, and then some one starts to tell about the number of gallstones removed from the bile duct of his aunt in Portland, Oregon.

Of course, you are called upon to explain the nature of your ailment, and you state that you are accredited by your physician with having too much hydrochloric acid in your stomach.

"Oh, how terrible!" exclaims your hostess. "Hydrochloric acid is poison, isn't it? I remember that from my high school chemistry."

"I had a friend, a scientist of some renown," remarks a sepulchral voice at your left elbow, "who fed vitamines—or was it calories?—to some white rats, and he passed away before the rats did. Odd, wasn't it?" And then he adds thoughtfully, "It was he who discovered that bacon really has more to do with the flavor of an egg than does the hen."

After this the dinner hour is almost wholly occupied by a discussion of disease, bacteria, operations, doctors and their weaknesses, and mistakes, treatments and their culminations, until you feel as if you were attending a meeting of the Pathological Section of the American Medical Association instead of dining at the home of a friend.

To diet well, one must be a person of some means. Next to one's physician, tailors and dressmakers profit most through the dieting of other persons. When a man gets thin, he of course has his suit cut down the better to fit his slender lines; and then when he takes on the fifteen pounds resultant from abstaining from the things he likes best to eat, the suit has to be let out. By this time it does not fit anyone in particular and to save it from the moths it is given to the gardener.

To the list of things that have robbed your life of most of its middle-age romance is appended a sort of Sunday supplement headed, "Principles Underlying Your Diet." The first line simply appalls you. It reads: "Avoid entirely tea, coffee, alcohol and tobacco."

Tea and coffee you think are only luke-warm habits, and Mr. Volstead, who made Minnesota famous, has eliminated all other stimulants from life except those which can be procured from books and lectures on the "New Psychology." But the tobacco! You linger long and mournfully over this item. The after-dinner cigar (or two or three) is another proposition. It is a well-established habit—smoking is. This strikes at the very root of things.

When your mind is in a turmoil it is your custom to go down to the club and smoke a cigar to smooth things out. And so you go down and light up and proceed to enjoy what may be your very last cigar on earth. You are just ready to light the second last one when a friend comes in and invites you to try one of his cigars. "You know,"

he says, "this is the kind you see advertised in the magazines. Made down in Tampa and wholesaled direct to the smoker from the manufacturer. Great idea, you know, this getting rid of the middleman." You take the cigar and find it so good that you determine at once to align yourself with those restless souls whose sole purpose in life is to eliminate the middleman.

It is odd how sometimes one's greatest difficulties, so great, in fact, that they seem about to overwhelm one, are so very easily overcome, and how what sometimes appears to be a tremendous problem is quickly and simply solved.

On the arrival of the cigars which come "direct from the manufacturer to the consumer," you enjoy a certain sense of pride as you unpack them, and removing the tin foil from one of them you proceed to light up. You think they are fine. The aroma appeals to your taste, and being an experienced smoker you assume that you ought to know all about tobacco.

You feel that you do not object to dieting and doing the thing as directed except upon special occasions, but this idea of a doctor's assuming to rob one of every privilege on earth to cure one from a distressful feeling in one's stomach is carrying things a little too far. Why can't a physician be reasonable and considerate? If it is necessary for a patient to quit smoking, to walk two miles down to the office every morning and to eat Dreaded Wheat Biscuit when the rest of the family breakfasts on bacon and eggs, why under the sun doesn't one run across a physician once in a while who is living so heroically?

However, you smoke up the first tier of cigars in the box and find that those in the lower part of the box have a peculiar aroma that was quite foreign to the uppermost layer. You think that your taste is changing, deteriorating perhaps; it does sometimes with smokers, you argue. You abstain for a couple of days altogether and finally give it up, your problem being solved before you are hardly aware of it. You feel like writing a letter to the manufacturers of the cigars thanking them for curing you of a bad habit.

The next time you meet a friend you say, "Let me see, did I tell you that I have quit smoking? Yes, sure I have. It's as easy as falling off a log if one has the right sort of will power; but I tell you after smoking for twenty years it *does* take some will power to quit. But it's really great to be free from all such things. You know the human tissues were never created to be drugged by stimulants and clogged by overeating. Why, think of it—what delicate mechanisms the cells of the body are and then we clog and poison them and work them overtime just because we are gluttonous and slaves to habit!"

Of course, dieting will be necessary as long as overeating and lack of proper mastication continue to be national habits, and one's heart

goes out to the person who is dieting. One feels that somehow he hasn't half a chance. To diet successfully, one should have meals served in the basement or in a room over one's garage where one cannot see the rest of the family eat or what they are eating!

812 Watts Building.

The Health of Children in Institutions

During childhood there is comparatively great susceptibility to certain types of diseases and to influences that may exert some retarding influence on growth and development. Some of these dangers, according to an editorial in the Journal A. M. A., are augmented by congestion of population and by systems of living that increase the possibility of contact infections. Probably these are some of the things responsible for the widespread impression that the institutional care of children is detrimental, or at least unfavorable, to health and proper nutrition. The difficulties seem to be accentuated further by the fact that the young who are consigned to the care of a sheltering institution are likely to come from homes or surroundings that are far from advantageous.

In considering the fate of children consigned to institutions where group living prevails, rather than to so-called foster homes where the individual dominates, we may overlook the great progress that has been made in recent years in the management of institutional inmates. The methods of housing and sanitation have been improved in many parts of the world; the problems of nutrition and personal hygiene have been approached with due recognition of recent contributions to the sciences they represent. Hence a student of child welfare has remarked that, in an institution where children are under full control day and night, it should be possible to eliminate malnutrition entirely, and the presence of a malnourished child among those who have been in the institution a sufficient time for study and treatment requires explanation. He asserts also that all correctional institutions for children, such as truant and parental schools, should be so organized as to seize the first moment a child comes under their control to look into his physical condition. Much of the disciplinary difficulty with these children, we are further told, is due to bad physical condition, and surprising results in the way of improved behavior frequently follow improved nutrition and the removal of defects.

That such aspirations are not futile has been clearly indicated in two independent reports published during the past year. Holt and Fales, who studied the children in a home and school for poor children

in New York within the heart of the uptown business section in a building "dark and rather gloomy" but subject to good sanitary and medical supervision, noted remarkably satisfactory conditions. They remark that the impression is prevalent that children living in institutions decline in general health and vitality, and that their growth and physical development are inhibited. Holt and Fales' observations of these children show that this is not a necessary result, and that the contrary may be true. The carefully controlled life in a properly managed institution, the regular hours, the good food, dental attention, and the lessened chances of infection, because the children do not come in contact with other children as do those who attend public school, make it possible to keep these children in excellent health; in fact, in much better condition than children in most private homes.

Equally encouraging is the tribute to institutional possibilities paid by Katz and Gray in a review of conditions in a recently investigated large home for children in Boston. Despite the strict regimen, children of the poorest class, when under proper institutional care, are shown to catch up rapidly to normal children in physical respects. The longer they stayed in the institution, the larger was the percentage of children who were above the average in nutrition and development. This is not the story of an exclusive private home; it relates to an institution in which malnutrition is not a cause for exclusion, but rather for admission. The time has probably arrived for counteracting the impression that children living in an institution tend to decline in vitality, and that their development may be inhibited. There are evidently many places where health is splendidly safeguarded even in the absence of much that constitutes "home" to the child.

FUTURE EVENTS

THE MASSACHUSETTS BOARD OF DENTAL EXAMINERS will hold an examination for registration for both dentists and oral hygienists at Boston, on October 13, 14, 15 and 16, 1924. Full information, application blanks, etc., may be secured at the office of the Secretary, Room 146, State House, Boston, Mass. All applications must be filed at least ten days before date set for said examination at the office of the Secretary.

J. N. CARRIERE, *Secretary.*

The Annual Clinic and Home Coming of THE CREIGHTON DENTAL ALUMNI ASSOCIATION will be held in Omaha at the Creighton Dental College, Oct. 23-24-25, 1924.

DR. O. A. RUNYON, *President,*
806 City Nat. Bank Bldg.
W. E. STOFT, *Secretary,*
521 City Nat. Bank Bldg., Omaha, Neb.

The next meeting of the NEW YORK STOMATOLOGICAL SOCIETY will be held on Monday, October 27, 1924, at 2 P. M., at 597 Fifth Avenue, New York City.

Dr. Stanley Slocum will give a clinic and present a paper on *The Technique of Porcelain Jacket Crowns and The Relationship to Periodontia.*

F. W. MCDONALD, D.D.S., *Secretary,*
33 West 42nd Street, New York.

The annual meeting of THE AMERICAN SOCIETY OF DENTAL RADIOGRAPHERS will be held at the Adolphus Hotel, Dallas, Texas, Friday and Saturday, November 7 and 8, 1924.

All dentists interested in radiography are invited to attend.

ARNOTT A. MOORE, *President,*
131 Allen Street, Buffalo, N. Y.
MARTIN DEWEY, *Secretary,*
501 Fifth Avenue, New York, N. Y.

A meeting for the purpose of organizing an AMERICAN DENTAL ASSISTANTS' ASSOCIATION will be held at Dallas, Texas, November 10-14, 1924. An invitation is extended to all dental assistants' societies to send a representative.

JULIETTE A. SOUTHARD, *Chairman,*
174 West 96th Street, N. Y. City.

The annual meeting of the NATIONAL ALUMNI CHAPTER OF THE PSI OMEGA FRATERNITY will be held at the Southland Hotel, Dallas, Texas, Monday, November 10, 1924.

The Executive Committee will meet at 10 A. M. The general meeting will start at 2 P. M., and everyone is urged to be on hand promptly.

A "stag" banquet will be held at 7 P. M. Reservations must be made by 4 P. M. Big surprise for those who attend!

LLOYD S. HUHN, *Grand Master,*
3166 Lincoln Avenue, Chicago, Ill.

THE CONNECTICUT DENTAL COMMISSION will meet at Hartford on November 18, 19 and 20, 1924, to examine applicants for license to practise dentistry and dental hygiene and to transact any other business proper to come before them. For further information apply to Arthur B. Holmes, Recorder, 43 Central Ave., Waterbury, Conn.

The next semi-annual meeting of the COLORADO STATE BOARD OF DENTAL EXAMINERS will be held in Denver, commencing December 2, 1924, and will continue for five days.

For further information, address:

WM. H. FLINT, D.D.S.,
Littleton, Colo.

THE IOWA STATE DENTAL BOARD will meet for the purpose of examining candidates for a license to practise in Iowa, at Iowa City, Ia., College of Dentistry, beginning Monday, December 8th, 1924, at 9 A. M. An examination for dental hygienists will be given.

All papers and credentials must be filed with the secretary 10 days prior to the date of the meeting.

For further information and application blanks, address

DR. C. B. MILLER, *Secretary,*
712 Equitable Bldg., Des Moines, Ia.